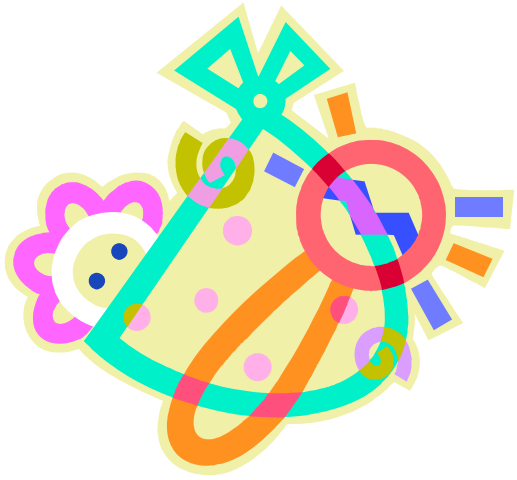
FIRST STEPS

DOCUMENTATION REQUIREMENTS PACKET



August 2005

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(Adobe Document)

First Steps Program Documentation Requirements Effective January 01, 2006

FIRST STEPS PROGRAM DOCUMENTATION REQUIREMENTS
EFFECTIVE JANUARY 1, 2006

PART I: CLIENT CHART CONTENT

CHARTING SYSTEM

Each First Steps Agency shall provide an efficient charting system for the accurate and complete documentation of MSS/ICM services. Agencies should have written policies and procedures that guide documentation practices. The charting system must have a centralized chart/file for MSS and ICM clients. The MSS chart/file will consist of all documentation for the maternity cycle, including all documentation from all MSS subcontractors. Infant Case Management (ICM) must be documented in a centralized file. The First Steps state team highly recommends that you establish separate charts for a mother and for her infant. *(See Appendix 3, Protecting Confidentiality of your Client's Health Information).*

The First Steps charting system must include:

- Registration information with client demographic and contact Information
- Documentation of client eligibility (PIC#)
- HIPAA-compliant information releases
- Freedom of choice acknowledgement
- Consent for care
- Required screening forms for appropriate period of service:
    - MSS Prenatal New Client
    - MSS Postpartum, Returning or New Client
    - MSS Initial Infant Client
    - ICM, Transition or New Client
- Plan for Care that allows for documentation of the interdisciplinary plan for the individual client's care
- Protocol for documenting case conferences
- A method for summarizing all Identified Risk Factors, date identified and status
- Methods for documenting evaluations and assessments, both standardized and non-standardized
- A focus on required Core Services
- Required Client Visit Records
- Interventions documented on the required Client Visit Record including:
    - basic health messages
    - referrals, advocacy, linkages, and
    - use of minimum interventions as protocols for care

- Methods for documenting client progress and/or increasing levels of practitioner support for basic health messages, linkages, and minimum interventions
- Required Outcome and Discharge Summaries
- A place for client's identifying information and date of service on each page (if paper system)
- Clinician signatures and titles according to professional standards (Refer to WAC246-810-035 and WAC246-335-110 for licensed mental health counselors, licensed social workers and home health records).
- Documentation of review by a professional member of the First Steps team for all client services delivered by a Community Health Worker

REQUIRED FORMS

First Steps requires the use of the following First Steps forms:

- MSS Prenatal New Client Screening or MSS Client Screening Tool
- MSS Postpartum Screening, New Client or Returning Client
- MSS Initial Infant Screening
- MSS Client Visit Records, with Mother and with Infant
- MSS Service Outcome and Discharge Summaries, Mother and Infant
- ICM Intake
- ICM Transition Questionnaire or New Client Screening*
- ICM Client Visit Record*
- ICM Outcome and Discharge Summary*

Agencies may use their own forms/formats for client registration, release of client information, documenting freedom of choice, signature log, plan for care, case conferencing, evaluations and assessments, and progress notes as long as the content that follows is included. In the following sections are details of requirements for documenting First Steps MSS and ICM client services.

PART II: CHART CONTENT DESCRIPTION

REGISTRATION

Demographic and contact information for the client must be documented in the client chart. At a minimum, the following information must be collected:

- Client Name
- Date of Birth
- Sex (M/F)
- Contact Information
- Marital Status
- Race (and if applicable, Ethnicity and Tribal Affiliation)
- Primary Language Spoken

- PIC Number and Effective Date
- Parent or guardian information for minors. NOTE: pregnant teens may choose not to share this information (RCW 9.02.100).

FREEDOM OF CHOICE

The Agency must provide a Freedom of Choice Declaration for all clients to read and sign. The declaration must inform the client that services are voluntary and she/he is free to choose any First Steps provider for First Steps services regardless of where she/he receives her prenatal, postpartum or pediatric medical care.

RELEASE OF INFORMATION

Each client chart must contain a valid, signed Release of Information. This form is agency-specific. It is recommended that the form be approved by the agency's legal counsel. Every 90 days after the initial signature, a new release of information form must be signed by the client. (70.02 RCW)

For ICM, the initial release can be a photocopy from the mother's chart. Once 90 days have expired, a new release of information needs to be signed by the birth parent and placed in the infant's chart. Every 90 days thereafter, a new release of information form must be signed by the parent and placed in the infant's chart. (70.02 RCW)

CONSENT FOR CARE

Each client chart must contain a signed Consent for Care. This form is agency-specific. It is recommended that the form be approved by the agency's legal counsel.

SIGNATURE LOG

All client charts must contain a signature log, with printed names and titles of all staff providing care, and their legal signature. If staff initials are used in the chart, a sample must be included on the signature log.

CLIENT SCREENING

Screening is required for each phase of First Steps services: MSS prenatal, postpartum and newborn, and Infant Case Management. There are required screening forms for each of these phases. Screening provides a method for systematically reviewing and documenting major risk factors, and areas of need or concern for an individual client. The screen is not intended to be an in depth assessment for each risk factor or area of concern or need. Once a risk factor or need/concern is identified, a practitioner may need to evaluate further.

Minimal format changes to the required screening forms are permissible. For example, check boxes may be changed to yes/no answers, the sequence of the questions may be changed, and the forms may be divided by discipline. **All**

content must be retained. *Please check with your First Steps DOH State Consultant County Lead before making any changes to the forms.*

Agencies must ensure that screening includes both a process for client input and face to face interaction.

All screening forms must be signed and dated in the spaces provided. Agencies are required to provide a method for documenting all risk factors identified during screening. Risk factors may be documented on either the MSS Plan for Care, an agency specific service/care plan, a problem/issue page, or on another summary page.

MSS Client Questionnaire: This questionnaire is not required. However, it is highly recommended as a first level screen and a method for understanding what the *client* considers important. It is a mechanism for developing a client centered plan of care and engaging the client.

MSS Prenatal New Client Screening: There are two options for completing the required prenatal screen. Agencies must use either the "Maternity Support Services Client Screening Tool" [DSHS 13-723 (REV. 10/2003)] or the "MSS Prenatal New Client Screening" (not yet a DSHS numbered form) to conduct and document the initial prenatal new client screen.

MSS Postpartum New Client or Returning Client Screening: Postpartum represents a dramatic change in client status; a new screening form is required to document current status. For clients seen in the prenatal period, use the "MSS Postpartum Returning Client Screening"; for clients newly referred postpartum, use the "MSS Postpartum New Client Screening".

MSS Initial Infant Screening: The "MSS Initial Infant Screening" collects information regarding the infant. This screening should be completed during the first postpartum visit with the client.

ICM Transition Questionnaire or New Client Screening:* For clients who have been seen in MSS and are now eligible for ICM, use the "ICM Transition Questionnaire". This form provides a chance to review the issues that will be the focus for ICM services. For clients who are newly referred for ICM services (have not been MSS clients), use the "ICM New Client Screening".

ICM INTAKE

An ICM Intake [DSHS 13-658 (REV. 06/2004)] must be present in the chart of each ICM client. This form shows eligibility, and is completed before the ICM screen. If the parent refuses ICM services or the client could not be located, note that on the Intake form and place it in the mother's chart.

PLAN FOR CARE

A plan for the individual client's care must be included in each client's chart. The plan for care must be based upon information from the initial screening visit, and revised as new risk factors are identified or when significant changes occur. A plan for care is required for MSS prenatal, postpartum, and infant services, and for ICM services.

Client Involvement to develop the plan for care is encouraged. Agencies may use the "MSS Plan for Care" and the "ICM Plan for Care" or may use their own versions.

Whether using the MSS/ICM Plans for Care or the agency's own format, the following must be included:

- Identification and prioritization of risk factors, other areas of need or concern identified during the initial screening and any further assessments; date identified should be noted
- Notation of standard care protocols, such as basic health messages and linkages, and minimum interventions
- Individual plans for this client
- Consideration given to client goals
- Documentation of case conference participants, decisions and recommendations
- Identification of individuals who participated in the care plan development
- Cultural and ethnic considerations
- If a risk factor is identified but will not be part of the plan for care, documentation explaining this decision is required. For example, the risk factor may be a low priority for the client.

The agency must have a process to review the care/service plan at least every trimester of the pregnancy.

CASE CONFERENCE

For MSS clients, agencies must provide a method for documenting case conferences. The initial case conference and any subsequent updates (or meetings/discussions) must be documented. Case conferences are documented on the contact log or an agency may provide an alternative format, such as a progress note, or an agency-specific form. All decisions and recommendations/plans for care must be documented. All staff present (including by phone) must be identified on the case conference note and on the Plan for Care if changes are made to the Plan for Care.

ASSESSMENT

Assessment or evaluation beyond screening may be necessary in some cases. Assessments may be informal, particularly when conducted by experienced professionals. The informal evaluation/assessment may be documented in one of the following ways:

- on the Client Visit Record (CVR)
- on the contact log
- on a format developed by agency

Standardized assessment tools have the advantage of applying standard measurement across clients and being useful for measurement of progress. Examples of standardized assessment tools are the Beck Depression Scale and the NCAST tools.

Completion of either informal or standardized evaluations/assessments should be noted on the client visit record for that visit with a reference to where in the chart the assessment may be found. Assessment should not duplicate the screening tool but should expand the content area being assessed.

DOCUMENTING CLIENT VISITS

The "Client Visit Record" (CVR) form is <u>required</u> for documenting client visits.

Follow-up from past visit(s) is documented in the left column. An example of what would be documented in the follow-up column would be if a client has not followed through on a previous referral and more support is needed for the client to succeed.

Document the area of focus for this visit in the middle column. Use check boxes to document interventions such as health messages and linkages. For other interventions or actions mark the "other" box and document the specific intervention.

If needed use the "Notes" column for continued documentation. Document observations, evaluations and any other specific information necessary to describe the visit in the "Notes" column.

Please note that there are separate CVR forms:

- MSS Client Visit Record with Mother
- MSS Client Visit Record with Infant
- ICM* Client Visit Record

For each visit, only document information about the risk factors addressed during that visit. The other spaces may be left blank. Significant risk factors noted on the Plan for Care should be prioritized. A very brief note of explanation

(e.g. “not addressed due to client’s other priorities”) should be written for any significant risk factor not addressed at the visit.

On the last page of the CVR is a space for “Next Steps”. In this space note briefly the plan for the immediate future. If significant changes have occurred the Plan for Care needs to be updated.

Minimal format changes to the required CVR forms to adapt to agency requirements are permissible. For example, check boxes may be changed to yes/no answers. **All content must be retained.** *Please check with your First Steps DOH State Consultant County Lead before making any changes to the forms.*

OUTCOME AND DISCHARGE SUMMARIES

For each MSS and ICM* client, the “Outcome and Discharge Summary” must be completed. The client’s name, date of discharge and reason for discharge is documented on the top of the form. This form documents progress toward client goals and outcomes of interventions/actions. Discharge Comments may be written at the end of each form.

MSS Mother Service Outcome and Discharge Summary:

Risk Factors Identified: For each risk factor identified during the time of service:

- Check the box to the left of the risk factor.
- If the risk factor was identified but not addressed, check one of the boxes stating “Client had other priorities” or “Client declined to address”.
- If client was referred and obtained services related to the risk factor, check the box “Assisted in obtaining appropriate services”.
- Check the box(es) in the right column showing the highest level(s) of outcome achieved.
- Fill in appropriate blanks, such as “Began prenatal care at _____.”

Risk Factors Not Identified: If the risk factor was not identified, check the box next to “Not evident as a risk factor”.

Other Factors: Three items are listed under “Other Factors”. For all MSS clients, the Birth/Delivery Outcomes must be completed (right hand column), if the client was seen through delivery. The other two factors and outcome information are completed when appropriate.

Performance Measures: For all clients, complete the Family Planning (Risk Factor 8) and Tobacco Cessation (Risk Factor 9) sections. Completing these sections completes the obligation for documenting these

two performance standards. *Consult the First Steps Billing Instructions for information about billing for performance measures.*

MSS Infant Service Outcome and Discharge Summary:

- For each outcome listed, the appropriate box should be marked to the right of the outcome.
- If all/always was not the outcome, then check the appropriate circle listed below the outcome.
- The statement(s) under each area of focus/intervention should be marked when applicable.

ICM Infant Service Outcome and Discharge Summary:* The format for this form will be similar to the MSS Infant Service Outcome and Discharge Summary.

Minimal format changes to the required Service Outcome and Discharge Summary forms to adapt to agency requirements are permissible. For example, check boxes may be changed to yes/no answers. **All content must be retained.** *Please check with your First Steps DOH State Consultant County Lead before making any changes to the forms.*

PART III: GENERAL DOCUMENTATION GUIDELINES

GENERAL GUIDANCE FOR DOCUMENTATION

The goal for documenting First Steps services is for the practitioner to document what is necessary to describe the service provided in a concise and efficient format. Identified risk factors should be able to be followed in a progression: from identification to inclusion in the plan for care, through visit records, ending with the outcome and discharge summary. For those risk factors that are identified and not addressed, notation about why they were not addressed should be in the chart.

Chart documentation of the date and duration of the visit must be the same as the date and duration of service billed to MAA.

Documentation should reflect the type of service being billed. For example, the behavioral health specialist note must reflect items within their scope of practice and the scope of the program.

Documentation must acknowledge and address discrepancies in information about client. For example, the client tells the nurse she is happy with her current living situation, but tells the social worker she is homeless and afraid.

On the required documentation forms, practitioners may write in margins; however, the goal is to have good documentation with less writing. The key is balancing good documentation with efficiency. Writing must be clear and legible.

Separate chart files for mother and baby are recommended. *(See Appendix 3).*

PART IV: STANDARDIZED LANGUAGE SYSTEMS

USING STANDARDIZED DOCUMENTATION LANGUAGES

For agencies using standardized documentation language, such as OMAHA, to document client services, the First Steps program is working on efforts to cross-walk. During the fall of 2005, forms using the OMAHA language will be a focus for the documentation project.

PART V: ELECTRONIC HEALTH RECORDS

ELECTRONIC HEALTH RECORDS (EHR)

The First Steps Program encourages the use of electronic documentation. Agencies using electronic documentation are expected to adhere to the same standards outlined for paper documentation, with the following exceptions:

- The **content** of the required forms is required; the format may be changed to facilitate ease of documentation in the electronic format.
- If a paper record is retained, it must contain the information from the required forms, and show how identified risk factors are followed in a progression from identification to inclusion in the plan for care, through visit records, and ending with the outcome and discharge summary. For those risk factors that are identified and not addressed, notation about why they were not addressed should be in the chart.
- If no paper record is retained, the content of the required forms must be documented and the ability to generate a report that meets the standards outlined in this section for monitoring review must exist.

Please check with your First Steps DOH State Consultant County Lead with questions.

**** ICM forms are being developed in Draft and will be circulated for comment in late summer of 2005.***

APPENDIX 1

Comprehensive List of Forms for First Steps Documentation

Comprehensive List of Forms for First Steps Documentation

Business Forms – *Sample Format:*

Client Registration

Freedom of Choice

Release of Client Information – no sample format, agency-specific

Consent for Care – no sample format, agency-specific

Service Unit Tracking

MSS/ICM Billing Information for Agency Business Office

Clinical Charting Forms – *Sample Format:*

Signature Log

Client Contact Log or MSS/ICM Contact Log and Service Tracking

MSS Client Questionnaire – highly recommended

MSS Plans for Care, Mother's and Infant's

Clinical Charting Forms – *Required Format:*

MSS Prenatal New Client Screening or MSS Client Screening Tool [DSHS 13-723 (REV. 10/2003)]

MSS Postpartum Screening, New or Returning Client

MSS Initial Infant Screening

MSS Client Visit Records, with Mother and with Infant

MSS Service Outcome and Discharge Summaries, Mother and Infant

ICM Intake – [DSHS 13-658 (REV. 06/2004)]

ICM Transition Questionnaire or New Client Screening

ICM Client Visit Record

ICM Outcome and Discharge Summary

APPENDIX 2

Provider Guide to Documentation Forms

PROVIDER GUIDE TO DOCUMENTATION FORMS

INTRODUCTION

This section describes in greater detail the First Steps forms that have been developed for use by provider agencies. The purpose and bulleted comments related to each form are provided below. The forms are divided into three categories: business forms, clinical charting forms for which samples are provided, and the required clinical charting forms. *(See Appendix 1, Comprehensive List of Forms for First Steps Documentation).*

BUSINESS FORMS – Sample Format

Client Registration

- This form is offered as an example of one way to obtain demographic information about a client separately from clinical information.
- This form is not required; however the information in the "Client Information" section and the left side of the "Medicaid/Insurance Information" section must be collected by the agency in some form.
- Other sections of this form are offered for agency use if desired, and may be deleted by agency choice.
- Social Security Numbers may be collected, or not, according to your agency policy.

Freedom Of Choice

- This form is offered as an example of how to document that a client has been offered freedom of choice in First Steps providers.
- This form is not required; however, each agency is required to document freedom of choice in the client chart.

Service Unit Tracking

- Many agencies have forms for tracking the number of units used for MSS and ICM clients. This form is one sample of how an agency might track and display units used and balance remaining.
- This particular form is not required; however, a formal method for tracking units and keeping First Steps practitioners informed of balance remaining is required.

Please refer to MSS and ICM billing instructions for specific billing information

MSS/ICM Billing Information for Agency Business Office

- This form is offered as an example of one way to communicate billing information to an agency's business office without including clinical information
- Agencies may use their own forms and processes.

Please refer to MSS and ICM billing instructions for specific billing information

CLINICAL CHARTING FORMS – FORMAT NOT REQUIRED

Signature Log

- The signature log contains a printed name, title, and signature for all staff involved in the client's care.
- Use of this form is not required; however, it is recommended that some version of a signature log be included in client charts.

Client Contact Log and MSS/ICM Contact Log and Service Tracking

- There are two versions of a chronological log for recording all significant contacts made with (or regarding) a client. They provide a quick chronological overview of contacts.
- "Client Contact Log" is a general log which does not include the tracking of MSS/ICM service units. This version is meant for agencies preferring to track units separately from the contact log.
- "MSS/ICM Client Contact Log and Service tracking" serves the same purpose as the client contact log, and includes service unit tracking specific to MSS and ICM.
- Use of either form is not required; however, agency must provide some version of a contact/chronological log for use by First Steps Practitioners.
- Contacts between staff, for the purpose of conferring about the client's services, (case conferences) are recorded on the log. Examples:
  - "Case conference. See Plan for Care. Staff signature."
  - "Conferred with PHN by phone. PHN will follow-up with client regarding breastfeeding. Staff signature."
- Notations on either version of the log are most often brief, often referring the reader to a more detailed description of the contact. Examples:
  - "Home Visit. See Client Visit Record. Staff signature."
  - "Initial Office Visit. See Screening Form. Staff signature."
  - "Telephone call from client canceling appointment. Rescheduled for __. Staff signature. "

MSS Client Questionnaire

- The questionnaire is intended to be filled out by the client, and therefore is written in client-friendly language.

- The questionnaire is not required; it provides one way to demonstrate client participation in care, or client-centered care. Agencies are expected to demonstrate client participation in identifying risk factors/issues, and planning for care.
- The questionnaire does not include every single screening issue, but rather can be used as a place to start when the MSS staff person conducts the screening interview.
- The questions/items on the client questionnaire relate to some of the risk factors in the core Services *(See Section____)*. For example, the first four questions and the items under the bolded section…."In the areas of pregnancy, my health, prenatal care……" relate to Risk Factor 1: Late Entry, Intermittent, or No Prenatal Care and, Risk Factor 2: Adjustment to Pregnancy.

MSS and ICM Plans for Care

- The Plan for Care is intended to describe the interdisciplinary plan of care for this individual client. This format is not required. However there must be a plan for care that reflects the plan for all disciplines.
- All risk factors identified in the prenatal screen would be noted on the plan for care. An alternative would be to maintain a list of all risk factors identified, bringing only the most significant 3 to the plan for care.
- The plan is meant to be central in the service providers' minds, consulted often, updated as new issues emerge, and it is meant to be amended, as issues are resolved.
- The plan is organized around the risk factors, and also includes space to add other areas of concern.
- In the first column, the date the issue is identified and the initials of the staff person identifying it should be noted.
- In the second column, the risk factor (or other concern) should be noted.
- In the third column, a brief description of the plan of action related to the risk factor should be noted. If the plan for care is to follow the minimum interventions, the box would be checked.
- In the fourth column, special notes and significant outcomes would be noted.

CLINICAL CHARTING FORMS - REQUIRED

MSS Prenatal New Client Screening

- This screening form is intended to be filled out by the MSS staff person conducting the screening interview, and serves to document all aspects of the visit.
- The staff person can begin by looking over the Client Questionnaire (which the client had already filled out), explaining that s/he appreciates that the client has completed it because it will help to tailor services to meet her needs. The staff person could continue by saying something like: "I'd like to

go into a little more detail with you about these things, and gather a bit more information…."

- It is intended to be user-friendly for the staff person, and therefore includes space for narrative and boxes for checking off interventions, linkages, and health messages that are likely to be completed at this visit.
- If the screening cannot be completed in one visit, subsequent date(s) of completion would be noted in the box at the top.
- Once the screening is completed, the Plan for Care is developed based upon risk factors identified. It is intended that all risk factors identified during the prenatal screening would be noted on the Plan for Care, regardless of outcome.

MSS Postpartum New Client or Returning Client Screening

- The first postpartum visit is recorded on a screening form. For the new client the more extensive Postpartum New Client Screening should be used. For the MSS client who has been followed in the prenatal period, the first postpartum visit is recorded on the Postpartum Returning Client Screening.
- Like the prenatal screening form, these forms include check boxes and space to record interventions.
- Once the screening is completed, the Plan for Care is updated or developed based upon risk factors identified. It is intended that all risk factors identified during the postpartum screening would be noted on the Plan for Care, regardless of outcome.

MSS Infant Initial Screening

- The MSS Infant Initial Screening provides the format for recording the infant's information gathered at the first postpartum visit. Like the prenatal screening form, this form includes check boxes and space to record interventions.
- Once the screening is completed, the Infant's Plan for Care is developed based upon risk factors identified. It is intended that all risk factors identified during the postpartum screening would be noted on the Plan for Care, regardless of outcome

ICM Intake

- This form documents client eligibility for Infant Case management Services. The form must be in the chart for each ICM client.

ICM Transition Questionnaire

- For clients who have been followed in the MSS program and are determined to be eligible for Infant Case Management, the ICM Client Transition Questionnaire refocuses the services to those now available under ICM.
- This questionnaire is intended to be filled out by the client; with this information and information gleaned from prior MSS visits, the ICM Plan for Care is developed.

ICM New Client Screening

- This screening form is intended to be filled out by the ICM staff person conducting the screening interview, and serves to document all aspects of the visit. It is intended to be user-friendly for the staff person, and therefore includes space for narrative and boxes for checking off referrals, linkages, and advocacy interventions that are likely to be completed at this visit.
- If the screening cannot be completed in one visit, subsequent date(s) of completion would be noted in the box at the top.
- Once the screening is completed, the ICM Plan for Care is developed based upon issues identified.

MSS and ICM Client Visit Records

- This form is intended to be used to document the details of each visit with the client, with the exception of the initial screening visit(s.)
- It was designed to take as little of the provider's time as possible, while still providing a complete picture of the service.
- The visit record is organized primarily around the MSS risk factors, with boxes provided next to health messages and common linkages, to be easily checked off as they are given.
- Please note that not every step in the Minimum Intervention Protocols is included as a check box. When providing an intervention without a specific check box, use the check box marked "Other" and include a note in the "Notes" section.
- Assessments are also noted in the notes section. Detailed assessments that are not recorded on their own forms may be documented on the contact log, with a reference in the CVR.
- Noting that the Plan of Care was consulted, and/or that it was changed as a result of the visit, is done by checking the appropriate boxes at the top of the front of the visit record and at the bottom of the back of the page.

MSS Mother and Infant, and ICM Service Outcome and Discharge Summaries

- This summary is intended to provide documentation of both the interventions/linkages made by MSS and ICM providers, and the outcomes related to the client's circumstances.
- It is intended to be completed upon termination of MSS and/or ICM services, regardless of reason for termination of services.
- For MSS, it is organized around the risk factors, minimum interventions, and also includes several additional relevant factors on the final page.
- The MSS Mother Outcome and Discharge Summary integrates the two performance measures (Tobacco and Family Planning), thus eliminating the need for separate documentation forms.
- Looking toward the future, data aggregated from this document will be useful in describing program services and outcomes.

APPENDIX 3

Protecting Confidentiality of your Clients' Personal Health Information

Protecting Confidentiality of your Clients' Personal Health Information

All information collected in the charts of First Steps clients is considered personal health information (PHI).

As First Steps providers, you must follow state and federal privacy laws and rules regarding the confidentiality of your clients' PHI. The First Steps state staff cannot interpret these laws for you or give you legal advice. We can however, make recommendations and provide you with resource information regarding confidentiality laws (cited at the end of this memo).

Although DOH and DSHS cannot regulate how you organize your client charts, the First Steps state team highly recommends that you establish separate charts for a mother and for her infant during Infant Case Management. This practice is in keeping with the fact that the mom and baby are two distinct clients and it protects you and the clients. For example, if there is sensitive information about a family member that affects the baby, it should be **referenced only** (e.g. "see mother's chart note dated xx-xx-xx) and **not** mentioned directly in the baby's chart. The practice of separate charts for mother and infant also makes it easier during site visits for the state staff to monitor what services are provided to each client.

For more detailed information on HIPAA privacy:

- contact your agency's Privacy Officer since all covered entities must have a Privacy Officer under the HIPAA privacy rules.
- go to the federal Department of Health and Human Services (DHHS) website http://www.hhs.gov/ocr/hipaa/.
- visit the Revised Code of Washington website, http://www.leg.wa.gov/RCW/index.cfm?fuseaction=chapterdigest&chapter=70.02 and look at RCW 70.02, specifically RCW 70.02.050(1)(e) and .130
- consult your agency's lawyers.

APPENDIX 4

List of State Consultant Contacts by County

First Steps MSS/ICM State Consultant Contacts by County

All Counties: Maureen (Mo) Lally, Infant Case Management, MAA, DSHS, (360)725-1655
Lenore Lawrence, CSO, Clearinghouse, Childcare, Website, (360)725-1666
Keri Acker-Peltier, Tribal Agencies and Tribal issues, (206) 265-9034

County	MSS Contact	Phone
Adams	Kathi LLoyd	(360) 236-3552
Asotin	Kathi LLoyd	(360) 236-3552
Benton-Franklin	Kathi LLoyd	(360) 236-3552
Chelan-Douglas	Cynthia Huskey	(360) 236-3599
Clallam	Cynthia Huskey	(360) 236-3599
Clark	Diane Bailey	(360) 236-3580
Columbia	Kathi LLoyd	(360) 236-3552
Cowlitz	Diane Bailey	(360) 236-3580
Garfield	Kathi LLoyd	(360) 236-3552
Grant	Cynthia Huskey	(360) 236-3599
Grays Harbor	Cynthia Huskey	(360) 236-3599
Island	Becky Peters	(360) 236-3532
Jefferson	Cynthia Huskey	(360) 236-3599
King	Becky Peters	(360) 236-3532
Kitsap	Cynthia Huskey	(360) 236-3599
Kittitas	Cynthia Huskey	(360) 236-3599
Klickitat	Diane Bailey	(360) 236-3580
Lewis	Diane Bailey	(360) 236-3580
Lincoln	Kathi LLoyd	(360) 236-3552
Mason	Cynthia Huskey	(360) 236-3599
Northeast Tri Counties (Ferry, Pend Oreille, Stevens)	Kathi LLoyd	(360) 236-3552
Okanogan	Cynthia Huskey	(360) 236-3599
Pacific	Cynthia Huskey	(360) 236-3599
Pierce	Diane Bailey	(360) 236-3580
San Juan	Becky Peters	(360) 236-3532
Skagit	Becky Peters	(360) 236-3532
Skamania	Diane Bailey	(360) 236-3580
Snohomish	Becky Peters	(360) 236-3532
Spokane	Kathi LLoyd	(360) 236-3552
Thurston	Diane Bailey	(360) 236-3580
Tribal Agencies & Issues	Keri Acker-Peltier	(206) 265-9034
Wahkiakum	Diane Bailey	(360) 236-3580
Walla Walla	Kathi LLoyd	(360) 236-3552
Whatcom	Becky Peters	(360) 236-3532
Whitman	Kathi LLoyd	(360) 236-3552
Yakima	Diane Bailey	(360) 236-3580

APPENDIX 5

First Steps MSS Forms

Business Forms - Samples

Chart # _____

CLIENT REGISTRATION

CLIENT INFORMATION

NAME: First /Middle/Last Maiden Name:		
Also Known As:		
Street Address/City/State/Zip		Date of Birth: Sex: ___ M ___ F
Address Change: date_____	Home Phone:	Cell Phone:
Address Change: date_____	Work Phone:	Email address:
Mailing Address: Address/City/State/ Zip Code		

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Unknown	Race: *(Check one or more*) ☐ White ☐ Black or African American ☐ American Indian* or Alaska Native ☐ Asian: Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian *(Specify):* ☐ Pacific Islander: or Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander *(Specify):* ☐ Other *(Specify)*:	Ethnicity: ☐ Spanish/Hispanic/Latino ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic *(Specify):* ☐ Unknown ☐ Other *(If applicable):*
Primary Language:	*Tribal Affiliation:	Agency Use
Interpreter Needed: Yes: _____ No: _____	Client Social Security # (*Agency option)*	

If the client is a child, please complete the following:

Mother's Name:	Mother's Maiden Name:	Father's Name/Age:
Mother's Social Security # *(Agency option*):	Father's Social Security # *(Agency option):*	
Mothers Address *(If different from patient):*	Father's Address *(If different from patient):*	
City, State, Zip	City, State, Zip	

May we contact you at your home address or phone number? ☐ **Yes** ☐ **No** *(If no, complete boxes to the right)* ⇨ May we identify ourselves? Yes ____ No ____ *(If no, code name _____)*	Alternate Address: City, State Zip	Alternate Phone(s):

EMERGENCY CONTACT INFORMATION

Name(s):	Phone Number(s):

MEDICAID/INSURANCE INFORMATION: *Please present your insurance card or medical coupon to the receptionist.*

PIC # (If Medicaid/Healthy Options):	Insurance Company:
Effective Date:	Policy Number:
Infant's PIC#:	Policy Holder' Name *(If different from patient):*
Effective date:	Policy Holder's Social Security Number:
Patient's relationship to Policy Holder (*Mark one*): ☐ Self ☐ Spouse ☐ Child ☐ Guardian	

FINANCIAL AND INSURANCE CERTIFICATION

I certify the financial and insurance information given is accurate and current. If insurance or Medicaid information is invalid, I understand I will receive a bill for the full fee for service. I authorize my insurance benefits be paid directly to the provider. I also authorize the provider or insurance company to release any information required for payment of this claim.

Signature:_____ Date: _____

FAMILY INFORMATION *(Please list all of your family members living in your home.)*

FAMILY MEMBERS	RELATIONSHIP TO CLIENT	DATE OF BIRTH

FREEDOM OF CHOICE

The First Steps Maternity Support Services/Infant Case Management Program offers you health services while you are pregnant and for a time after the baby is born.

Services are available through *(your agency name)* or through another program of your choice. If you wish, please ask for a list of other First Steps providers.

What happens next:

1. A plan will be developed with you to assist you in having a healthy baby.
2. You may receive services from a nurse, a nutritionist, a behavioral health specialist, a community health worker, and/or an infant case manager.

____ Yes, I would like to receive Maternity Support Services through *(your agency name).*

____ Yes, I would like to receive Infant Case Management Services through *(your agency name).*

_____No, I do not wish to receive services through *(your agency name).*

Client Signature: _____Date: _____

SAMPLE

MSS/ICM Service Tracking

Date of Service	Staff Initials	Today's # of 15-Minute units used*		Running Total of Units Used*	
		MSS	ICM	MSS	ICM

Office and Home Visits **are billable** in First Steps Program.

Telephone Calls and Case Conferences **are not billable** in First Steps Program.

** See billing instructions for specific information*

Client Name _____ Date of Birth _____

SAMPLE

MSS/ICM BILLING INFORMATION
FOR AGENCY BUSINESS OFFICE

Service provided by:_____
Staff Signature

Please ***PRINT COMPLETE LEGAL*** name:

Client:_____
Last First MI

PIC #_____
(*Always complete and update)*

Effective Dates: Beginning_____

PREV NAME or MOM (If Child)_____ Ending_____

DATE of BIRTH_____ Agency #_____

VISIT STATUS: _____First Visit this year _____First Visit _____Repeat Visit **LMP:** _____

Date of Service	**Place of Service**		**Procedure Code – Description**		**# of Units *(1 unit = 15 min)***
_____	Office		T1002-O	RN Services-Office	_____
_____	Home		T1002-H	RN Services-Home	_____
_____	Office		S9470-O	Nutritional Services - Office	_____
_____	Home		S9470-H	Nutritional Services – Home	_____
_____	Office		96152-O	Behavioral Health Services-Office	_____
_____	Home		96152-H	Behavioral Health Services -Home	_____
_____	Office		T1019-O	Community Health Worker-Office	_____
_____	Home		T1019-H	Community Health Worker-Home	_____
_____	H	O	T1023	Family Planning Performance Measure	1 x only
_____	H	O	S9075	Tobacco Cessation Performance Measure	1 x only

Dx Code: V22.2 Pregnant State, Incidental

_____	H	O	T1017	Targeted Infant Case Management	_____

Dx Code: V20.1 Health supervision of infant

Agency Specific _____

==========

Clinical Charting Forms - Samples

Signature Log

Agency: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Name *(Print)*: _____ Title *(RN, RD, etc)*: _____

Signature: _____ Initials: _____

Client Name: _____ Date of Birth: _____

CLIENT CONTACT LOG

Contact Type: OV = Office Visit HV = Home Visit TC = Telephone Call CC = Case Conference

Staff Discipline: RD = Registered Dietician CHN = Community Health Nurse
BHS = Behavioral Health Specialist CHW = Community Health Worker

DATE	CONTACT TYPE	STAFF	NOTES

First Steps Program: Office and Home Visits **are billable**.
Telephone Calls and Case Conferences **are not billable**.

See Billing Instructions for Specific Information

Client Name: _____ Date of Birth: _____

MSS/ICM CLIENT CONTACT LOG AND SERVICE TRACKING

Contact Type: OV = Office Visit HV = Home Visit TC = Telephone Call CC= Case Conference

Staff Discipline: RD = Registered Dietician
BHS = Behavioral Health Specialist
CHN = Community Health Nurse
CHW = Community Health Worker

DATE	CONTACT TYPE	STAFF	UNITS BILLED TODAY*	TOTAL UNITS BILLED	NOTES

FIRST STEPS PROGRAM: OFFICE AND HOME VISITS **ARE BILLABLE**
TELEPHONE CALLS AND CASE CONFERENCES **ARE NOT BILLABLE**

**SEE BILLING INSTRUCTIONS FOR SPECIFIC INFORMATION*

Client Name: _____ Date of Birth: _____

WELCOME TO MATERNITY SUPPORT SERVICES

Maternity Support Services (MSS) are preventive health services provided by a team including nurses, nutritionists, behavioral health specialists (counselors), and, in some agencies, community health workers. The main goal of MSS is to help you have a healthy pregnancy. You can receive Maternity Support Services during your pregnancy and through the end of the second month after your pregnancy is over.

PLEASE FILL OUT THIS QUESTIONNAIRE TO HELP US SERVE YOU BETTER

Your Name: _____ Your Birthdate: _____

1. Is this your first pregnancy? ☐ Yes ☐ No

2. Have you seen a doctor or midwife for your pregnancy? ☐ Yes ☐ No
   If yes, what is your doctor or midwife's name? _____

3. What date does your doctor or midwife say your baby is due? Date:_____ ☐ I am not sure.

4. Has your doctor/midwife said there are problems with your pregnancy? ☐ Yes ☐ No
   If yes, what are the problems? _____

BELOW ARE SOME OF THE THINGS MSS STAFF CAN HELP YOU WITH. TO HELP US MEET YOUR NEEDS. PLEASE CHECK THE BOXES THAT YOU WOULD LIKE TO KNOW MORE ABOUT OR HAVE HELP WITH.

In the areas of pregnancy, my health, prenatal care, getting ready for my baby, and the time right after my baby is born, I would like to know more about or have help with:

- ☐ Finding a doctor
- ☐ What to expect during doctor visits while I'm pregnant
- ☐ Body changes in pregnancy
- ☐ Dealing with discomforts in pregnancy
- ☐ Dangers in pregnancy
- ☐ Health problems I haven't talked to a doctor about
- ☐ How my health problems might affect my baby
- ☐ Problems with my teeth
- ☐ Quitting my tobacco use
- ☐ Asking people not to smoke in my home
- ☐ Getting into childbirth classes
- ☐ Breastfeeding
- ☐ Taking care of myself after my baby is born
- ☐ Birth control
- ☐ Taking care of my newborn baby
- ☐ Being a new parent
- ☐ Getting into classes for new parents
- ☐ Other:_____

In the areas of food, eating, and safe exercises I would like to know more about or have help with:

- ☐ Diet and weight gain
- ☐ Eating to help my baby grow
- ☐ Simple Exercises
- ☐ Menu Planning
- ☐ Other _____

In the areas of feelings, relationships, and coping with stress, I would like to know more about or have help with:

- ☐ Mood changes in pregnancy
- ☐ Dealing with past problems
- ☐ My feelings about past losses in my life
- ☐ Feeling scared or nervous about being a parent
- ☐ Getting along with my partner, or other people in my life
- ☐ Depression
- ☐ Anger
- ☐ Making new friends
- ☐ Dealing with stress
- ☐ Violence or fighting in my home
- ☐ Alcohol or drug use
- ☐ Having someone to talk with about my worries
- ☐ Other _____

In the area of other basic needs, I would like to know more about or have help with:

- ☐ Where to get clothing
- ☐ Where to get food
- ☐ Getting rides to the doctor or other important places
- ☐ Finding a better place to live
- ☐ Finding childcare
- ☐ Finding a doctor for my baby
- ☐ Finding a school
- ☐ Finding a job
- ☐ Finding a dentist
- ☐ Finding an eye doctor
- ☐ Family planning
- ☐ Other _____

I have other questions or worries: ☐Yes ☐No

If you want to, you can write them below:

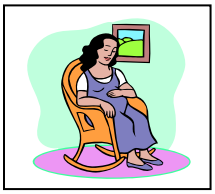
_____

_____

_____

_____

THANK YOU! WE LOOK FORWARD TO WORKING WITH YOU.



MSS PLAN FOR MOTHER'S CARE

☐ ALL BASIC HEALTH MESSAGES WILL BE GIVEN, ACCORDING TO AGENCY'S PROTOCOL
☐ BASIC REFERRALS AND LINKAGES WILL BE MADE

DATE IDENTIFIED & STAFF INITIALS	AREA OF FOCUS	PLAN OF ACTION (DATE IF REVISING)	NOTES/OUTCOMES
	ANTEPARTUM ☐ RISK FACTOR 1: PRENATAL CARE	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	ANTEPARTUM ☐ RISK FACTOR 2: ADJUSTMENT TO PREGNANCY	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	ANTEPARTUM ☐ RISK FACTOR 3: MATERNAL GRIEF/LOSS	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	ANTEPARTUM ☐ OTHER:		
	☐ BASIC NEEDS/SAFETY/ ENVIRONMENT	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 4: COGNITIVE IMPAIRMENT/ DEVELOPMENTAL DISABILITIES	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	NUTRITION: ☐ RISK FACTOR 5: FOOD AVAILABILITY	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	NUTRITION: ☐ RISK FACTOR 6: SKIPPED MEALS	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	NUTRITION: ☐ OTHER		

Client Name: _____ Date of Birth: _____

Staff Signature(s): _____ Date: _____

DATE IDENTIFIED & STAFF INITIALS	AREA OF FOCUS	PLAN OF ACTION (DATE IF REVISING)	NOTES/OUTCOMES
	☐ RISK FACTOR 7: MEDICAL/HEALTH/ NUTRITION CONDITIONS	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	POSTPARTUM: ☐ BREASTFEEDING	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	POSTPARTUM: ☐ ADJUSTMENT TO PARENTING		
	POSTPARTUM: ☐ OTHER		
	☐ RISK FACTOR 8: FAMILY PLANNING	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 9: TOBACCO USE/ SECONDHAND SMOKE	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 10: MENTAL HEALTH CONCERNS	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 11: ALCOHOL/SUBSTANCE USE	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 12: INADEQUATE SOCIAL SUPPORT	☐ MINIMUM INTERVENTIONS* ☐ OTHER	

Client Name: _____ Date of Birth: _____

Staff Signature(s): _____ Date: _____

DATE IDENTIFIED & STAFF INITIALS	AREA OF FOCUS	PLAN OF ACTION	NOTES/OUTCOMES
	☐ RISK FACTOR 13: DOMESTIC VIOLENCE	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 14: CPS INVOLVEMENT	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 15: COPING AND STRESS	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ RISK FACTOR 16: HISTORY OF ABUSE	☐ MINIMUM INTERVENTIONS* ☐ OTHER	
	☐ OTHER		
	☐ OTHER		

** AS FOUND IN MSS POLICY AND PROCEDURE MANUAL*

Client Name: _____ Date of Birth: _____

Staff Signature(s): _____ Date: _____

MSS PLAN FOR INFANT'S CARE

☐ ALL BASIC HEALTH MESSAGES WILL BE GIVEN, ACCORDING TO AGENCY'S PROTOCOL
☐ BASIC REFERRALS AND LINKAGES WILL BE MADE

DATE IDENTIFIED & STAFF INITIALS	AREA OF FOCUS	PLAN OF ACTION (DATE IF REVISING)	NOTES/OUTCOMES
	NEWBORN INFANT HEALTH		
	NUTRITION/FEEDING/GROWTH		
	DEVELOPMENT/INFANT BEHAVIOR/ BONDING		
	SAFETY		
	OTHER		

Client Name: _____ Date of Birth: _____

Staff Signature(s): _____ Date: _____

Clinical Charting Forms - Required

HM = Health Message
RF = Risk Factor
* Items = HM or Linkage

MSS PRENATAL NEW CLIENT SCREENING

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at Visit: _____

Date: _____ Time visit started: _____ ☐AM ☐PM Time visit ended: _____☐AM ☐PM

(If 2nd screening visit) Date: _____ Time visit started: _____☐AM ☐PM Time visit ended: _____☐AM ☐PM

Client Name: _____ Date of Birth: _____

Doctor /Midwife's Name: _____ Date Prenatal Care Started: _____

Expected Date to Deliver: _____ Ethnic Group: _____

Receiving medical coupons every month? ☐ Yes ☐ No If so, PIC #: _____

On a Healthy Options Plan? ☐Yes ☐No Which Plan? _____Will the baby have the same plan? ☐Yes ☐No

Are you receiving other prenatal or other case management services? ☐ Yes ☐ No _____

ANTEPARTUM: RF 1 PRENATAL CARE / RF 2 ADJUSTMENT TO PREGNANCY (RF 3 MATERNAL GRIEF)

1. How many times have you been pregnant? _____
2. How many live births have you had? _____
3. How long has it been since you last gave birth? _____
4. **Have you ever had pre-term labor or a premature birth? ☐ Yes ☐ No**
5. Have you ever had a C-section? ☐ Yes ☐ No
6. How many of your children are living with you? _____
7. Was this pregnancy: ☐ planned ☐ not the right time ☐ unexpected ☐ other _____
8. When did you know you were pregnant? _____
9. Which of these areas would you like to learn about? ☐ pregnancy ☐ labor and delivery ☐ newborn care ☐ adjusting to parenting ☐ breastfeeding ☐making your home safe for baby ☐ other _____
10. What are your feelings/baby's father's feelings about this pregnancy?

_____

_____

NOTES:

_____

_____

INTERVENTIONS:

☐ Facilitated appt. with OB provider*
☐ Gave CB Ed schedule*
☐ Gave information re: pediatrician resources*
☐ Informed re: counseling resources*
☐ Referred for counseling*
☐ Gave *Nine Months to Get Ready**
  ☐HM: Importance of prenatal care*
  ☐HM: Physical changes of pregnancy*
  ☐HM: Psychological changes of pregnancy*
  ☐HM: Preterm labor*
  ☐HM: Warning signs in pregnancy*
  ☐HM: Importance of physical exercise in pregnancy*
☐ HM: Bonding and attachment*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

BASIC NEEDS/SAFETY/ENVIRONMENT

11. What is your living situation?
☐ Buying or ☐ Renting:
☐ apartment ☐ house ☐ room ☐ other _____
Staying: ☐ with friends/family ☐ shelter
☐ car ☐ motel ☐ other_____
12. Who lives with you? _____

_____
13. Do you have smoke detectors in your home?
☐Yes ☐No

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred for housing * _____
☐ Gave housing resources list *
☐ Referred to _____

☐ Referred to _____ (for smoke alarm)*

Client Name: _____ Date of Birth: _____

14. Have you checked them and do they work? ☐Yes ☐No

15. Do you have guns in your home? ☐Yes ☐No

16. Are your guns locked? ☐Yes ☐No

17. Do you have dependable transportation for medical appointments and other activities? ☐Yes ☐ No

18. Do you have a safe car seat for your child? ☐Yes ☐No

19. Are there religious or cultural practices in your life that you would like us to know about to help us serve you better? ☐Yes ☐ No

_____

_____

20. Are you on Temporary Assistance to Needy Families (TANF)? ☐ Applied ☐ Yes ☐ No

21. Are you employed? ☐ Yes ☐ No

22. Is your partner employed? ☐ Yes ☐ No

23. What grade did you last finish in school? _____

☐ Gave gun safety handout
☐ Gave gun lock

☐ Referred for Transportation*
☐ Referred to DSHS *

☐ Gave information re: car seat safety*
☐ Gave car seat resources *
☐ Gave car seat
☐ Gave safety check list
☐ Gave info re: CPR training resources*
☐ Referred to: _____*
☐ Referred to DSHS *
☐ Referred to Employment Security*
☐ HM: Environmental Dangers*

NOTES:
_____
_____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 4 COGNITIVE IMPAIRMENT/DEVELOPMENTAL DISABILITIES

24. Were there things about school that were especially hard? ☐ Yes ☐ No _____

25. Were you in Special Education classes? ☐ Yes ☐ No

NOTES:
_____
_____

INTERVENTIONS:
☐ Referred for Special Education Services*
☐ Referred for DDD services*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

NUTRITION: RF 5 FOOD AVAILABILITY AND RF 6 SKIPPED MEALS

26. Are you on Food Stamps? ☐ Yes ☐ No ☐ Applied

27. What are your concerns about food, eating, or weight?
_____

28. In the last month, did you ever cut the size of your meals or skip meals because there was not enough money for food or because you were concerned about weight gain? ☐ Yes ☐ No

29. What cravings do you have for non-food items like dirt, cornstarch, paint chips, or ice? _____
_____

30. How much coffee, tea, and soda pop do you drink?
_____

31. How many times per week do you eat out? _____

32. What vitamins or supplements do you take? _____
_____

NOTES:
_____
_____

INTERVENTIONS:
☐ Referred to WIC Agency: _____
☐ Referred to Food Bank*
☐ Discussed ideal eating patterns during pregnancy
☐ Problem-solved ways to avoid skipping meals
☐ Discussed beverage options
☐ HM: Proper nutrition*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name: _____ Date of Birth: _____

RF 7 MEDICAL/HEALTH/NUTRITION CONDITIONS

33. Is your blood low in iron? ☐Yes ☐ No ☐ Don't know

34. Do you have high blood pressure? ☐Yes ☐No ☐Don't know

35. Do you now have or did you have diabetes during your pregnancies? ☐ Yes ☐ No ☐ Don't know

36. Do you have any other medical conditions? ☐Yes ☐ No

    Condition: _____

37. Are you taking any medicine (prescription, over the counter or other? ☐ Yes ☐ No

38. Have you experienced nausea, vomiting, heartburn, or constipation during your pregnancy? ☐N ☐V ☐H ☐C

39. Have you had problems with weight gain / loss (circle) during this pregnancy? ☐ Yes ☐ No

40. Are your immunizations up to date? ☐Yes ☐ No

41. Have you had a dental check-up in the last year? ☐Yes ☐ No

42. Do you have broken/decayed teeth? ☐Yes ☐ No

43. What regular exercise do you do and how often?

    _____

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred to MD for medical concerns *
☐ Referred to _____ *
☐ HM: Oral Health *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

POSTPARTUM/BREASTFEEDING PLANS

44. How are you planning to feed your baby?
    ☐ Breast ☐ Bottle ☐ Both

45. Are you planning to go to work or school after birth?
    ☐ Yes ☐ No

NOTES:

_____

_____

INTERVENTIONS:
☐ Referred to BF class *
☐ HM: Breastfeeding (in *Nine Months to Get Ready* *)

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 8 FAMILY PLANNING

46. Are you planning to use birth control after this birth?
    ☐ Interested in learning more
    ☐ Considering birth control
    ☐ Has a plan for birth control
    ☐ Not interested

47. Where will you get your birth control? _____

    _____

NOTES:

_____

_____

INTERVENTIONS:

☐ HM: Family Planning (in *Nine Months to Get Ready*)*
☐ Gave contraception information
☐ Gave information about state-funded contraception and sterilization services

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name: _____ Date of Birth: _____

RF 9 TOBACCO USE/SECONDHAND SMOKE

48. Have you ever used tobacco? ☐ Yes ☐ No
49. Do you use tobacco now? ☐ Yes ☐ No
50. If yes, would you like help making a plan to quit? ☐ Yes ☐ No
51. Are you exposed to 2nd hand smoke? ☐ Yes ☐ No
52. If yes, would you like help making a plan to stop being exposed? ☐ Yes ☐ No

NOTES:

_____

_____

INTERVENTIONS:

☐ Advised to quit tobacco use (if unwilling, advised to cut down)
☐ No exposure to 2nd hand smoke
☐ Advised to avoid 2nd hand smoke
☐ Helped client develop a quit plan
☐ Helped client develop a plan for remaining tobacco free
☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke
☐ Gave "No Smoking, Baby Breathing" sign *
☐ Gave 1-800 Quit line card *
☐ Gave Fresh Start information guide *
☐ Gave "How Other Moms Have Quit"
☐ HM: Tobacco/Second Hand Smoke *
☐ Had client sign fax back release form

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 10 MENTAL HEALTH CONCERNS

53. Are you, or is someone else, concerned about your mental health? ☐ Yes ☐ No
54. Have you ever received mental health counseling? ☐ Yes ☐ No
55. Have you ever been depressed? ☐ Yes ☐ No
56. Over the past 2 weeks, have you felt:
    Depressed? ☐ Yes ☐ No Hopeless? ☐ Yes ☐ No
    Unable to enjoy things you usually enjoy? ☐ Yes ☐ No
57. Have you been more irritable/anxious than usual? ☐ Yes ☐ No
58. Are you taking prescription medications? ☐Yes ☐ No

_____

☐ Family hx of depression

☐ In counseling

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred to _____*
☐ Gave handout re: PPMD*
☐ HM: Postpartum Depression*

COMPLETED BY: _____ _____
STAFF SIGNATURE DATE

RF 11 ALCOHOL/SUBSTANCE USE

59. Has anyone in your family ever had any problems with drugs or alcohol? ☐ Yes ☐ No
60. Have you used alcohol / drugs *(circle)* just before or during this pregnancy? ☐ Yes ☐ No
61. Have you ever had any problems with drugs or alcohol? ☐ Yes ☐ No
62. Has someone you live with ever had any problems with drugs / alcohol *(circle)*? ☐ Yes ☐ No

NOTES:
☐ In treatment

_____

_____

INTERVENTIONS:

☐ Referred to substance abuse treatment provider *
☐ Referred to AA *
☐ Referred to Alanon *
☐ Referred to NA
☐ HM: Drug/alcohol use during pregnancy *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name: _____ Date of Birth: _____

RF 12 Social Support

63. Have you / your partner *(circle)* ever had legal problems? ☐ Yes ☐ No
64. Have you / partner *(circle)* ever been in jail? ☐ Yes ☐ No
65. Who can you count on for help / support during this pregnancy?_____
66. Who can you talk to about stressful things in your life? _____

NOTES:
_____
_____

INTERVENTIONS
☐ Discussed ways to increase support
☐ Referred to legal advocacy resource:_____
☐ HM: Importance of support system*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 13 Domestic Violence / RF 14 CPS

67. Do you worry about somebody mistreating you? ☐Yes ☐ No
68. Are you afraid of your partner? ☐ Yes ☐ No
69. Has your partner ever put you down, said hurtful things, or threatened you? ☐ Yes ☐ No
70. Has your partner ever pushed, hit, kicked, or physically hurt you? ☐ Yes ☐ No
71. Has your partner ever threatened or forced you to have sexual contact? ☐ Yes ☐ No
72. Do you worry about anyone mistreating your child / children? ☐Yes ☐ No

☐ Has a safety plan

NOTES:
_____
_____

INTERVENTIONS:
☐ Referred to DV services: _____
☐ Assisted with a safety plan
☐ Facilitated contact with DV services_____
☐ CPS discussed
☐ CPS report made *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 15 Coping and Stress

73. What are some of the ways that you cope with stress? _____
74. How well do these things work for you?

Not at all OK Very well *(circle)*

75. When problems come up in your life, how do you feel about your ability to handle them? I usually need:

A lot of help Some help No help *(circle)*

76. What are some of the ways you deal with anger? (yours/other people's) _____
77. How well do these things work for you?

Not at all OK Very well *(circle)*

NOTES:
_____
_____

INTERVENTIONS:
☐ Discussed potential effects of stress in pregnancy
☐ Discussed strategies for coping with stress
☐ Referred to _____*
☐ HM: Self care and coping *

COMPLETED BY: _____ _____
STAFF SIGNATURE DATE

Client Name: _____ Date of Birth: _____

RF 16 HISTORY OF ABUSE AND OTHER ISSUES

78. Is there anything else that is causing you to worry or have concerns about your pregnancy, your family, your living situation, or another part of your life?

☐ History of physical/sexual abuse

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred to _____*

COMPLETED BY: _____ _____

STAFF SIGNATURE **DATE**

☐ Obtained authorizations for exchange of information

NEXT STEPS

Refer to: ☐MSS Nurse ☐MSS Behavioral Health Specialist ☐MSS Nutritionist ☐MSS CHW ☐Other _____

☐ Recommend further evaluation re: _____

☐ **Develop Plan of Care based on issues identified in screening visit(s) and with input from client**

Next Appointment Date: _____

Notes (Optional): _____

_____

_____

_____

_____

Staff Signature: _____ **Date:** _____

Client Name: _____ Date of Birth: _____

MSS POSTPARTUM NEW CLIENT SCREENING

HM = Health Message
RF = Risk Factor
* Items = HM or Linkage

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at Visit: _____

Date: _____ Time visit started _____ ☐AM ☐PM Time visit ended: _____ ☐AM ☐PM
(If 2nd screening visit) Date: _____ Time visit started _____ ☐AM ☐PM Time visit ended: _____ _☐AM ☐PM

Client Name: _____ Date of Birth: _____

Date Prenatal Care Began: _____ Doctor / Midwife's Name: _____

Baby's Name: _____ Baby's Date of Birth: _____

Are you receiving Medical Coupons every month? ☐ Yes ☐ No PIC #: _____

On a Healthy Options Plan? ☐Yes ☐No Which Plan? _____ Is baby's doctor on that plan? ☐Yes ☐No

Are you receiving other postpartum support services? ☐ Yes ☐ No _____

POSTPARTUM: BREASTFEEDING/ADJUSTMENT TO PARENTING

1. How many times have you been pregnant?_____
2. How many live births have you had? _____
3. How long has it been since you last gave birth? _____
4. Was your delivery: ☐ Vaginal ☐ C-section?
5. Did you have any infections? ☐Yes ☐ No
6. Did you have any health conditions during your pregnancy, such as: ☐Hepatitis B ☐HIV ☐TB?
7. Are you having any problems related to your delivery? ☐Yes ☐No
8. When is your next check up with your doctor? _____
9. Are you taking any medicines, (prescription, over-the-counter or other?) ☐Yes ☐No
10. Are you bleeding? ☐Yes ☐No
11. Are you having pain? ☐ Yes ☐No
12. Are you having any other problems, such as fever? ☐Yes ☐No
13. Are you having any problems urinating? ☐Yes ☐No
14. Are you having normal bowel movements? ☐Yes ☐No
15. Are you breastfeeding? ☐ Yes ☐ No ☐ Sometimes
16. Do you have any questions about breastfeeding? ☐Yes ☐No
17. Are you drinking 4 – 6 8 oz glasses of liquid per day? ☐Yes ☐No
18. How is your appetite? ☐ Same as before ☐Poor ☐ Increased
19. Are you concerned about your weight? ☐Yes ☐No
20. How are you sleeping, when you get the chance?
    ☐ No problems sleeping ☐Hard time falling asleep
    ☐ Waking up more than usual ☐Nightmares

☐ Group B Strep
☐ Hepatitis B
☐ HIV
☐ TB

NOTES:

_____
_____
_____
_____
_____
_____

INTERVENTIONS:
☐ Referred to doctor for _____
☐ Facilitated appointment with doctor
☐ Teaching re: postpartum self care
☐ Assisted with breastfeeding
☐ Developed breastfeeding support plan
☐ Referred to _____ for breastfeeding support*
☐ HM: Breastfeeding (in *Nine Months to Get Ready* *)
☐ HM: Self Care for Mom*
☐ HM: Post Partum Mood Disorders*
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

21. Do you get all the help you need with the baby? ☐Yes ☐No

22. What advice are you getting from family and/or friends about taking care of yourself? _____

_____

NOTES:

_____

_____

_____

_____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

BASIC NEEDS/SAFETY/ENVIRONMENT

23. What is your living situation?
☐ Buying or ☐ Renting:
☐ apartment ☐ house ☐ room ☐ other_____
Staying: ☐ with friends/family ☐ shelter
☐ car ☐ motel ☐ other_____

24. Who lives with you?

_____

_____

25. Do you have smoke detectors in your home? ☐Yes ☐No

26. Have you checked them, and do they work? ☐Yes ☐No

27. Do you have guns in your home? ☐Yes ☐No

28. Are your guns locked? ☐Yes ☐No

29. Do you have dependable transportation for medical appointments and other activities? ☐Yes ☐No

30. Do you have a safe car seat for your child? ☐Yes ☐No

31. Are there religious or cultural practices in your life that you'd like to tell us about to help us serve you better?
☐Yes ☐No _____

32. Are you on Temporary Assistance to Needy Families (TANF)? ☐ Applied ☐Yes ☐No

33. Are you employed? ☐Yes ☐No

34. Are you planning to go to work or school? ☐Yes ☐No

35. Is your partner employed? ☐Yes ☐No

36. What grade did you last finish in school? _____

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Referred for housing * _____
☐ Gave housing resources list *
☐ Referred to:_____
☐ Referred to _____ (for smoke alarm) *

☐ Gave gun safety handout
☐ Gave gun lock
☐ Referred for Transportation*
☐ Referred to DSHS *
☐ Gave information re: car seat safety *
☐ Gave car seat resources *
☐ Gave car seat
☐ Gave safety check list
☐ Gave info re: CPR training resources *
☐ Gave information re: finding childcare
☐ Referred to: _____*
☐ Referred to DSHS *
☐ Referred to Employment Security*
☐ HM: Environmental Dangers *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 4 COGNITIVE IMPAIRMENT/DEVELOPMENTAL DISABILITIES

37. Were there things about school that were especially hard? ☐Yes ☐ No _____

38. Were you in Special Education classes? ☐Yes ☐No

NOTES:

_____

_____

INTERVENTIONS:

☐ Referred for Special Education Services*
☐ Referred for DDD services *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name:_____ Date of Birth:_____

NUTRITION: RF 5 FOOD AVAILABILITY AND RF 6 SKIPPED MEALS

39. Are you on Food Stamps? ☐ Applied ☐Yes ☐No
40. What are your concerns about food, eating, or weight?
_____
41. Do you ever cut the size of your meals or skip meals because there isn't enough money for food or because you were concerned about weight gain? ☐Yes ☐No
42. How much coffee, tea, and soda pop do you drink?
_____
43. How many times per week do you eat out?_____
44. What vitamins or supplements do you take? _____
_____

NOTES:

☐ History of eating disorder

_____

INTERVENTIONS:

☐ Referred to WIC Agency: _____
☐ Referred to Food Bank *
☐ Referred for food stamps
☐ Discussed ideal eating patterns during pregnancy
☐ Problem-solved ways to avoid skipping meals
☐ Discussed beverage options
☐ HM: Proper nutrition *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 7 MEDICAL/HEALTH/NUTRITION CONDITIONS

45. Is your blood low in iron? ☐Yes ☐No ☐ Don't know
46. Do you have high blood pressure? ☐Yes ☐No ☐Don't know
47. Do you now have or did you have diabetes during your pregnancies? ☐ Yes ☐ No ☐ Don't know
48. Do you have any other medical conditions? ☐Yes ☐No
Condition: _____
49. Do you have any concerns about your weight? ☐Yes ☐No
50. Are your immunizations up to date? ☐Yes ☐No
51. ☐ Don't know
52. Have you had a dental check-up in the last year? ☐Yes ☐No
53. Do you have broken/decayed teeth? ☐Yes ☐No
54. What regular exercise do you do and how often?
_____

NOTES:

_____

INTERVENTIONS:

☐ Referred to MD for medical concerns *
☐ Referred to dentist for dental concerns*
☐ Referred to _____ *
☐ HM: Oral Health *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 8 FAMILY PLANNING

55. Are you planning to use birth control?
☐ Interested in learning more
☐ Considering birth control
☐ Has a plan for birth control
☐ Not interested
56. Where will you get your birth control? _____
_____

NOTES:

_____

INTERVENTIONS:

☐ HM: Family Planning (in *Nine Months to Get Ready*)*
☐ Gave contraception information
☐ Gave information about state funded contraception and sterilization services

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name:_____ Date of Birth:_____

RF 9 TOBACCO USE/SECONDHAND SMOKE

57. Have you ever used tobacco? ☐Yes ☐No
58. Do you use tobacco now? ☐Yes ☐No
59. Are you thinking about starting to smoke again? ☐Yes ☐No
60. If yes, would you like help making a plan to quit, or keeping from starting again? ☐Yes ☐No
61. Are you exposed to 2nd hand smoke? ☐Yes ☐No
62. If yes, would you like help making a plan to stop being exposed? ☐Yes ☐No

NOTES:

INTERVENTIONS:

- ☐ Advised to quit tobacco use (if unwilling, advised to cut down)
- ☐ No exposure to 2nd hand smoke
- ☐ Advised to avoid 2nd hand smoke
- ☐ Helped client develop a quit plan
- ☐ Helped client develop a plan for remaining tobacco free
- ☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke
- ☐ Gave "No Smoking, Baby Breathing" sign *
- ☐ Gave 1-800 Quit line card *
- ☐ Gave Fresh Start information guide *
- ☐ Gave "How Other Moms Have Quit"
- ☐ HM: Tobacco/Second Hand Smoke *
- ☐ Had client sign fax back release form

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 10 MENTAL HEALTH CONCERNS

63. Are you or is someone else concerned about your mental health? ☐Yes ☐No
64. Have you ever received mental health counseling? ☐Yes ☐No
65. Have you ever been treated for depression? ☐Yes ☐No
66. Over the past 2 weeks, have you felt:
    - Sad, depressed, crying without knowing why? ☐Yes ☐No
    - Scared, worried, irritable for no good reason? ☐Yes ☐No
    - Unable to enjoy things you usually enjoy? ☐Yes ☐No
    - Unable to see the funny side of things as you usually can? ☐Yes ☐No
    - Hopeless that things will get better? ☐Yes ☐No
67. Have you had any thoughts of hurting yourself or the baby? ☐Yes ☐No
68. Are you taking medications for mental health reasons? ☐Yes ☐ No _____

- ☐ Family hx of depression
- ☐ In counseling:

NOTES:

INTERVENTIONS:

- ☐ Referred to _____ *
- ☐ Gave mental health crisis number
- ☐ Facilitated mental health services appointment
- ☐ Gave handout re: PPMD*
- ☐ HM: Postpartum Depression*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 11 ALCOHOL / SUBSTANCE USE

69. Has anyone in your family ever had any problems with drugs or alcohol? ☐Yes ☐No
70. Have you used alcohol / drugs *(circle)* just before or during your pregnancy? ☐Yes ☐No
71. Has anyone ever told you they were worried about your alcohol / drug use *(circle)*? ☐Yes ☐No
72. Have you ever had any problems with drugs or alcohol? ☐Yes ☐No
73. Has someone you live with ever had any problems with drugs or alcohol (circle)? ☐ Yes ☐No

☐ In treatment

NOTES:

INTERVENTIONS:

☐ Referred to substance abuse treatment provider *
☐ Referred to AA *
☐ Referred to Alanon *
☐ Referred to NA
☐ HM: Drug / alcohol use during pregnancy *

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

RF 12 SOCIAL SUPPORT

74. Have you / your partner *(circle)* ever had legal problems? ☐ Yes ☐ No
75. Have you / partner *(circle)* ever been in jail? ☐Yes ☐No
76. Who can you count on for help / support during this postpartum time?_____
77. Who can you talk with about stressful things in your life? _____

NOTES:

INTERVENTIONS:

☐ Discussed ways to increase support
☐ Referred to legal advocacy resource: _____
☐ HM: Importance of support system *

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

RF 13 DOMESTIC VIOLENCE / RF 14 CPS

78. Do you worry about somebody mistreating you? ☐Yes ☐No
79. Are you afraid of your partner? ☐Yes ☐No
80. Has your partner ever put you down, said hurtful things, or threatened you? ☐Yes ☐No
81. Has your partner ever pushed, hit, kicked, or physically hurt you? ☐Yes ☐No
82. Has your partner ever threatened or forced you to have sexual contact? ☐Yes ☐No
83. Do you worry about anyone mistreating your child / children? ☐Yes ☐No

☐ Has a safety plan

NOTES:

INTERVENTIONS:

☐ Referred to DV services: _____
☐ Assisted with a safety plan
☐ Facilitated contact with DV services_____
☐ CPS discussed
☐ CPS report made *

COMPLETED BY:_____ _____
STAFF SIGNATURE **DATE**

Client Name:_____ Date of Birth:_____

RF 15 COPING AND STRESS

84. What are some of the ways that you cope with stress?
_____

85. How well do these things work for you?

Not at all OK Very well *(circle)*

86. When problems come up in your life, how do you feel about your ability to handle them? I usually need:

A lot of help Some help No help *(circle)*

87. What are some of the ways you deal with anger? (yours / other people's)
_____

88. How well do they work for you?
Not at all OK Very well *(circle)*

NOTES:

INTERVENTIONS:

☐ Discussed potential effects of stress in pregnancy
☐ Discussed strategies for coping with stress

☐ Referred to _____*

☐ HM: Self care and coping *

COMPLETED BY: _____ _____
STAFF SIGNATURE DATE

RF 16 HISTORY OF ABUSE AND OTHER ISSUES

89. Is there anything else that is causing you to worry or have concerns in any other areas, such as your family, your living situation or another part of your life? _____
_____
_____
_____

☐ History of physical/sexual abuse

NOTES:

INTERVENTIONS:
☐ Referred to _____*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

☐ Obtained authorizations for exchange of information

NEXT STEPS

Refer to: ☐MSS Nurse ☐MSS Behavioral Health Specialist ☐MSS Nutritionist ☐MSS CHW ☐Other _____

☐ Recommend further evaluation re: _____

☐ **Develop Plan of Care based on issues identified in screening visit(s) and with input from client**

Next Appointment Date: _____

Notes (Optional): _____

Staff Signature: _____ **Date:** _____

Client Name:_____ Date of Birth:_____

HM = Health Message
* Items = HM or Linkage

MSS POSTPARTUM RETURNING CLIENT SCREENING

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at visit: _____

Today's Date: _____ Time visit started: _____☐AM ☐PM Time visit ended: _____ ☐AM ☐PM

(If 2nd screening visit) Date: _____Time visit started: _____ ☐AM ☐PM Time visit ended: _____☐AM ☐PM

Client Name: _____ Date of Birth: _____

Baby's Name: _____ Doctor / Midwife's Name: _____

Baby's Date of Birth: _____ Still receiving Medical Coupons every month? ☐ Yes ☐ No

PIC #: _____ Which Health Options Plan? _____ ☐None

Is baby's doctor on that plan? ☐ Yes ☐ No Which plan does your baby have? _____

Are you receiving other postpartum support services? ☐ Yes ☐ No _____

POSTPARTUM: BREASTFEEDING / ADJUSTMENT TO PARENTING

1. Was your delivery ☐ Vaginal ☐ C-section?
2. Did you have any infections? ☐ Yes ☐ No
3. Are you having any problems related to your delivery? ☐ Yes ☐ No
4. When is your next check up with your doctor? _____
5. Are you taking any medicines, (prescription, over-the-counter or other?) ☐ Yes ☐ No
6. Are you bleeding? ☐ Yes ☐ No
7. Are you having pain? ☐ Yes ☐ No
8. Are you having any other problems, such as fever? ☐ Yes ☐ No
9. Are you having any problems urinating? ☐ Yes ☐ No
10. Are you having normal bowel movements? ☐ Yes ☐ No
11. Are you breastfeeding? ☐ Yes ☐ No ☐ Sometimes
12. Do you have any questions about breastfeeding? ☐ Yes ☐ No
13. How is your appetite? ☐ Same as before ☐Poor ☐ Increased
14. Are you drinking 4 – 6 8 oz glasses of liquid per day? ☐ Yes ☐ No
15. Are you concerned about your weight? ☐ Yes ☐ No
16. How are you sleeping, when you get the chance?
    ☐ No problems sleeping ☐Hard time falling asleep
    ☐ Waking up more than usual ☐Nightmares
17. Do you get all the help you need with the baby? ☐ Yes ☐ No
18. What advice are you getting from family and/or friends about taking care of yourself? _____

_____

☐ Group B Strep
☐ Hepatitis B
☐ HIV
☐ TB

Notes:

_____
_____
_____
_____
_____

INTERVENTIONS:

☐ Referred to doctor for _____
☐ Facilitated appointment with doctor
☐ Teaching re: postpartum self care
☐ Assisted with breastfeeding
☐ Developed breastfeeding support plan
☐ Referred to _____ for breastfeeding support*
☐ HM: Breastfeeding (in *Nine Months to Get Ready* *)
☐ HM: Self Care for Mom*
☐ HM: Post Partum Mood Disorders*
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

19. Over the past 2 weeks, have you felt:

Sad, depressed, crying without knowing why? ☐Yes ☐No

Scared, worried, irritable for no good reason? ☐Yes ☐No

Unable to enjoy things you usually enjoy? ☐Yes ☐No

Unable to see the funny side of things as you usually can? ☐Yes ☐No

Hopeless that things will get better? ☐Yes ☐No

☐ Family hx of depression
☐ In counseling: _____

NOTES:

_____

_____

_____

_____

20. Have you had any thoughts of hurting your self or the baby? ☐Yes ☐No

21. Is there anything else that is causing you to worry or have concerns in any other areas, such as your family, your living situation, or another part of your life? ☐Yes ☐ No

_____

_____

INTERVENTIONS:
☐ Referred to _____ *
☐ Gave mental health crisis number
☐ Facilitated mental health services appointment
☐ Gave handout re: PPMD*
☐ HM: Postpartum Depression*

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 9 TOBACCO USE / SECONDHAND SMOKE

22. Do you use tobacco now? ☐Yes ☐No

23. Are you thinking about starting to smoke again? ☐Yes ☐No

24. If yes, would you like help making a plan to quit, or keeping from starting again? ☐Yes ☐No

25. Are you exposed to 2nd hand smoke? ☐Yes ☐No

26. If yes, would you like help making a plan to stop being exposed? ☐Yes ☐No

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Advised to quit tobacco use (if unwilling, advised to cut down)
☐ No exposure to 2nd hand smoke
☐ Advised to avoid 2nd hand smoke
☐ Helped client develop a quit plan
☐ Helped client develop a plan for remaining tobacco free
☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke
☐ Gave "No Smoking, Baby Breathing" sign *
☐ Gave 1-800 Quit line card *
☐ Gave Fresh Start information guide *
☐ Gave "How Other Moms Have Quit"
☐ HM: Tobacco/Second Hand Smoke*
☐ Had client sign fax back release form

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

RF 11 ALCOHOL / SUBSTANCE USE *(COMPLETE THE FOLLOWING IF RISK FACTOR WAS PRESENT DURING PREGNANCY)*

28. Has your alcohol / drug *(circle)* use changed since your baby was born? ☐ Yes ☐ No

_____

_____

29. Has the alcohol / drug *(circle)* use of someone you live with changed since your baby was born? ☐ Yes ☐ No

30. Is there anything else that is causing you to worry or have concerns in any other areas, such as your family your living situation or another part of your lfie? _____

_____

_____

NOTES:

_____

_____

_____

☐ In treatment _____

_____

_____

INTERVENTIONS:

☐ Referred to Growing Together *
☐ Referred to AA *
☐ Referred to Alanon *
☐ Referred to NA
☐ HM: Drug / alcohol use during pregnancy *

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

NEXT STEPS

Refer to: ☐MSS Nurse ☐MSS Behavioral Health Specialist ☐MSS Nutritionist ☐MSS CHW ☐Other _____

☐ Recommend further evaluation re: _____

☐ **Develop Plan of Care based on issues identified in screening visit(s) and with input from client**

Next Appointment Date: _____

Notes (Optional): _____

_____

_____

_____

_____

Staff Signature _____ Date _____

Client Name :_____ Date of Birth: _____

MSS INITIAL INFANT SCREENING

HM = Health Message
* = HM or Linkage

☐ Home Visit ☐ Office Visit ☐ Other _____ Present at Visit: _____

Today's Date: _____ Time visit started: _____☐AM ☐PM Time visit ended: _____ ☐AM ☐PM

(If 2nd screening visit) Date: _____Time visit started: _____ ☐AM ☐PM Time visit ended: _____ ☐AM ☐PM

Baby's Name: _____ ☐M ☐F Date of Birth: _____ Gestation: _____wks

Doctor's Name: _____ Which Healthy Options Plan is your baby on? _____

Mother's Name: _____ Date of Birth: _____

NEWBORN INFANT HEALTH

1. How much did your baby weigh at birth? →
2. How long was he/she? →
3. How much does your baby weigh now? →
4. What was your baby's head circumference? →
5. Did you or your baby have any health problems at the time of birth, or in the hospital? _____
6. If so, did the doctor tell you to bring the baby in for follow-up? _____
7. Did your baby have her/his newborn screening heel stick? ☐Yes ☐No
8. Did your baby have her/his first newborn checkup at the doctor's office? ☐ Yes ☐No
9. If not, when is the appointment? _____
10. Do you know at what ages your baby needs his/her shots? (immunizations) ☐ Yes ☐ No
11. How many wet diapers does your baby have in 24 hrs? →
12. How many dirty diapers (bowel movements) does your baby have in 24 hours? →
13. Does anyone ever smoke around your baby? ☐ Yes ☐No
    ☐ In same room ☐ In house ☐ In car
14. Do you have any concerns about your baby's health? _____ ☐Yes ☐No
15. Do you know some signs to look for that might mean your baby is sick? _____ ☐ Yes ☐No
16. Do you know how to take your baby's temperature? ☐ Yes ☐No
17. Do you have a thermometer? ☐ Yes ☐No
18. When did your baby's doctor say you should call him/her about:
    Jaundice (yellow skin) _____
    Fever _____
    Other signs of illness _____
19. Do you know how to reach your baby's doctor after hours? ☐ Yes ☐No
20. Do you know what kinds of things you can do to protect your baby's future teeth? ☐ Yes ☐No

Birth weight _____ Current weight _____

Birth length _____ Head circumference _____

☐ Group B Strep ☐ TB ☐ HIV ☐ Hepatitis B
☐ Other _____
☐ Had follow-up: _____
☐ Needs follow-up: _____
☐ Mother can take temperature and interpret reading
☐ Knows not to put baby to bed with a bottle

NOTES:

_____
_____
_____
_____
_____

# of wet diapers / 24 hrs _____

# of bowel movements / 24 hrs _____

INTERVENTIONS:

☐ Discussed how to ask others not to smoke near baby
☐ Gave info re: dangers of second hand smoke
☐ Gave info re: smoking and breast milk
☐ Gave MYFSF Booklet
☐ Gave Quit line
☐ Checked cord
☐ Reviewed cord care instructions
☐ Gave health promotion information
☐ Reviewed immunization schedule
☐ Reviewed instructions for taking temperature
☐ Reviewed how to reach provider after hours
☐ Gave basic oral health information
☐ Other: _____
☐ HM: Baby Basics*
☐ HM: Well child visits
☐ Facilitated appointment with baby's doctor

Referred to:
☐ MD
☐ Other _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

NUTRITION / FEEDING / GROWTH

21. Are you breastfeeding your baby?
☐ Yes ☐ No ☐ Sometimes

22. Are you formula feeding your baby?
☐ Yes ☐ No ☐ Sometimes

23. How often do you feed your baby? _____

24. Are you feeding your baby anything other than breast milk or formula? ☐ Yes ☐ No _____

25. Do you have any questions about feeding? ☐ Yes ☐No
_____

26. Do you have any questions or concerns about your baby's growth? ☐ Yes ☐No

_____

_____

_____

_____

NOTES:

_____

_____

INTERVENTIONS:

☐ HM: Breastfeeding (In *Nine Months to Get Ready* *)
☐ Assistance with breastfeeding
☐ Gave information re: nutritional needs
Referred to:
☐ WIC
☐ Dietician
☐ Lactation Consultant
☐ _____ for breastfeeding support
☐ MD
☐ Other _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

DEVELOPMENT/INFANT BEHAVIOR/BONDING

27. What are your baby's sleep patterns? _____

_____

28. Are there times when your baby is usually alert?
☐ Yes ☐ No

29. Are there times when s/he's usually fussy?
☐ Yes ☐ No

30. Is your baby usually easy to calm down when s/he's fussy?
☐ Yes ☐ No

31. When your baby is crying, can you usually tell what s/he seems to need? ☐ Yes ☐ No

32. How would you describe your baby's personality (temperament)? _____

33. (If baby's father is involved) Has your baby's father described your baby's personality (temperament)?

_____

34. What advice about taking care of your baby do you get from your family and /or friends? _____

_____

_____

_____

☐ Sleep patterns appear typical for age
☐ Fussy periods appear typical for age
☐ Awake periods appear typical for age
☐ Mother describes baby in positive terms
☐ Mother's behavior indicates sensitivity
☐ Mother is appropriately responsiveness to baby

NOTES:

_____

_____

_____

INTERVENTIONS:

☐ Discussed that one can't "spoil" an infant
☐ Gave age appropriate developmental information
☐ HM: Bonding and Attachment*
☐ Referred for developmental evaluation
☐ Referred to Parenting Class
☐ Referred to MD
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

Client Name: _____ Date of Birth: _____

SAFETY

35. Does your baby sleep on his/her back? ☐Yes ☐No
36. Do you know infant CPR? ☐ Yes ☐ No
37. Does your baby ride in an infant seat every time? ☐ Yes ☐ No
38. Do you know about the dangers of shaking a baby or tossing them in the air? ☐ Yes ☐ No
39. Do you have pets? ☐ Yes ☐ No
40. Are there any unwanted animal pests in or around your home? ☐ Yes ☐ No
41. Are you concerned about someone hurting your baby? ☐ Yes ☐ No

NOTES:

_____

_____

☐ Mother knows never to shake infant

Pets inside: _____

Pets outside: _____

Animal Pests: _____

INTERVENTIONS:

☐ Contacted _____ to advocate for client
(agency)

☐ Gave information re: animal safety
☐ Gave information re: dangers of shaking baby
☐ Referred for CPR training
☐ Gave car seat safety information
☐ Gave car seat
☐ Gave Back to Sleep / SIDS information
☐ HM: Baby Basics*
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

OTHER

42. Do you need to look for childcare? ☐ Yes ☐ No
43. Are there certain areas you would like to learn more about? For example:
    - ☐ infant / baby care
    - ☐ dealing with infant crying
    - ☐ when to call my baby's doctor
    - ☐ how my baby lets me know what s/he needs
    - ☐ infant feeding
    - ☐ ways to play with my baby
    - ☐ how to make my home safer
    - ☐ other: _____
44. Is there anything else that is causing you to worry or have concerns in any other areas, such as your family, your living situation, or another part of your life? ☐ Yes ☐ No

Notes:

_____

_____

_____

_____

_____

INTERVENTIONS:

☐ Gave information re: finding childcare
☐ Other: _____

COMPLETED BY: _____ _____
STAFF SIGNATURE **DATE**

☐ Obtained authorizations for exchange of information

NEXT STEPS

Refer to: ☐MSS Nurse ☐MSS Behavioral Health Specialist ☐MSS Nutritionist ☐MSS CHW ☐Other _____

☐ Recommend further evaluation re: _____
☐ **Develop Plan for Care based on issues identified in screening visit(s) and with input from client**

Notes (Optional): _____

_____

Staff Signature _____ Date _____

Next Appointment Date: _____

Client Name: _____ Date of Birth: _____

MSS CLIENT VISIT RECORD WITH MOTHER

Client Name: _____ Date of Birth: _____ Visit Date: _____

☐ HV ☐ OV Present at visit: _____

Time visit started: _____ ☐ AM ☐ PM Time visit ended: _____ ☐ AM ☐ PM

☐ See Infant's Chart for Additional Information: _____
Infant's Name

**Asterisked items indicate linkages and health messages (HM). Descriptions of minimum interventions can be found in the First Steps Policy and Procedures Manual under Client Services. RF = Risk Factor*

FOLLOW-UP FROM LAST VISIT	Has Plan	Contacted	Received	INTERVENTION/ACTIONS	NOTES
ANTEPARTUM: RF 1 PRENATAL CARE / RF 2 ADJUSTMENT TO PREGNANCY (RF 3MATERNAL GRIEF)					
OB provider: ☐ ☐ ☐ Childbirth Ed: ☐ ☐ ☐ Breastfeeding Class: ☐ ☐ ☐ Other:				☐ Gave list of OB providers* ☐ Facilitated appt. with OB provider * ☐ Gave Childbirth Ed schedule* ☐ Facilitated registration for CBE class ☐ Referred to breastfeeding class* ☐ Gave *Healthy Mothers/Healthy babies phone #* ☐ Gave *Nine Months to Get Ready** ☐ HM: Importance of prenatal care* ☐ HM: Physical changes of pregnancy* ☐ HM: Psychological changes of pregnancy* ☐ HM: Preterm labor* ☐ HM: Warning signs of pregnancy ☐ HM: Importance of physical exercise in pregnancy* ☐ HM: Bonding and attachment* ☐ Other _____	
BASIC NEEDS/SAFETY/ENVIRONMENT					
DSHS: ☐ ☐ ☐ Housing: ☐ ☐ ☐ Transportation: ☐ ☐ ☐ Clothing: ☐ ☐ ☐ Work: ☐ ☐ ☐ School: ☐ ☐ ☐ Smoke Alarm: ☐ ☐ ☐ Other:				☐ Referred to DSHS* ☐ Gave housing resources list ☐ Referred for housing application* ☐ Referred for transportation* ☐ Referred to Employment Security* ☐ Referred for school: _____* ☐ Referred to _____ (smoke alarm)* ☐ Gave information re: car seat safety* ☐ Gave car seat resources* ☐ Gave car seat ☐ Gave safety check list ☐ Gave gun safety handout ☐ Gave gun lock ☐ Gave info re: CPR training resources* ☐ Referred to: _____* ☐ HM: Environmental Dangers* ☐ Other_____	

Staff Initials: _____ Date: _____

FOLLOW-UP FROM LAST VISIT (Has Plan / Contacted / Received)	**INTERVENTIONS/ACTIONS**	**NOTES**
RF 4 COGNITIVE IMPAIRMENT/DEVELOPMENTAL DISABILITIES		
DDD: ☐☐☐ Special Ed: ☐☐☐ Other:	☐ Referred for Special Education Services* ☐ Referred for DDD services* ☐ Assisted in obtaining DDD services * ☐ Other_____	
NUTRITION: RF 5 FOOD AVAILABILITY / RF 6 SKIPPED MEALS		
Food Bank: ☐☐☐ Food Stamps: ☐☐☐ Other:	☐ Referred to Food Bank* ☐ Referred for Food Stamps* ☐ Discussed ideal eating patterns ☐ Addressed avoiding skipping meals ☐ Discussed question of eating disorder ☐ Discussed beverage options ☐ Discussed iron rich foods ☐ Other _____	
RF 7 MEDICAL/HEALTH/NUTRITION CONDITIONS		
MD: ☐☐☐ Oral health: ☐☐☐ Other:	☐Specific Condition(s)_____ _____ ☐Referred to MD for medical concerns* ☐Referred to oral health resources* ☐Facilitated oral health/medical appointment * ☐ HM: Oral Health* ☐ Other _____	
POSTPARTUM/BREASTFEEDING/PARENTING		
Breastfeeding Support: ☐☐☐ Parenting Class: ☐☐☐ ☐☐☐ Mom's MD: ☐☐☐ Other:	☐ Discussed benefits of breastfeeding ☐ Assisted with breastfeeding ☐ Referred to _____for breastfeeding support* ☐ Referred to Parenting Class* ☐ Referred to MD* ☐ HM: Well Child Care* ☐ HM: Baby Basics* ☐ HM: Bonding and Attachment* ☐ HM: Normal Growth and Development* ☐ HM: Child Profile and Health Promotion* ☐ HM: Self Care for Mom* ☐ HM: Post Partum Mood Disorders* (All in *Nine Months to Get Ready*) ☐ Other: _____	

Client Name: _____ Date of Birth: _____

Staff Initials: _____ Date: _____

FOLLOW- FROM LAST VISIT UP	Has Plan	Contacted	Received	INTERVENTIONS/ACTIONS	NOTES
RF 8 FAMILY PLANNING					
Family planning method ☐ ☐ ☐ **WILL GET CONTRACEPTION FROM:** ☐Medical Care Provider ☐FP Clinic ☐CSO FP Nurse ☐Other_____ Method Planned_____ Other:				☐ Referred to MD/Nurse Practitioner ☐ Gave contraception information ☐ Gave info about state-funded contraception and sterilization services (Take Charge) ☐ Discussed ideal family size ☐ HM: Family Planning (in *Nine Months to Get Ready*)* ☐ Other _____	☐Stated hopes/dreams re: ideal family size ☐Stated she's thought about HIV and STDs ☐Decided to use contraception
RF 9 TOBACCO USE/SECONDHAND SMOKE					
Quit line: ☐ ☐ ☐ Other:				☐ Advised to quit tobacco use (if unwilling, advised to cut down) ☐ Advised to avoid 2nd hand smoke ☐ Helped client develop a quit plan ☐ Helped client develop a plan for remaining tobacco free ☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke ☐ Gave "No Smoking, Baby Breathing" sign* ☐ Gave 1-800 Quit line card* ☐ Gave Fresh Start information guide* ☐ Gave "How Other Moms Have Quit" ☐ Referred to available support systems _____ _____ ☐ HM: Tobacco/Second Hand Smoke* ☐ Had client sign fax back release form	☐ No current tobacco use ☐ No change in tobacco use ☐ Change in tobacco use _____ ☐ No interest in changing tobacco use ☐ Interest in changing tobacco use ☐ No change in 2nd hand exposure ☐ Change in 2nd hand exposure _____ ☐ No interest in changing 2nd handexposure ☐ Interest in decreasing 2nd hand exposure ☐ Decreased 2nd hand exposure
RF 10 MENTAL HEALTH CONCERNS					
Counseling: ☐ ☐ ☐ Other:				☐ Informed of counseling options* ☐ Assisted in obtaining mental health services* ☐ Other _____	
RF 11 ALCOHOL/SUBSTANCE USE					
AA: ☐ ☐ ☐ Al Anon: ☐ ☐ ☐ NA: ☐ ☐ ☐ Treatment: ☐ ☐ ☐ Other:				☐ Discussed risks of alcohol and other substance use to the baby ☐ Assisted in obtaining treatment services* ☐ Referred to _____ * ☐ Referred to AA ☐ Referred to Al Anon* ☐ Referred to NA* ☐ Other _____	☐No interest in changing alcohol use ☐Interest in changing alcohol use ☐Decreased alcohol use to _____ ☐Stopped alcohol use ☐No change ☐No interest in changing drug use ☐Interest in changing drug use ☐Decreased drug use ☐Stopped drug use ☐In treatment ☐No change

Client Name: _____ Date of Birth: _____

Staff Initials: _____ Date: _____

FOLLOW-UP FROM LAST VISIT (Has Plan / Contacted / Received)	INTERVENTIONS / ACTIONS	NOTES
RF 12 SOCIAL SUPPORT		
Social support: ☐ Has Plan ☐ Improved Other:	☐ Discussed ways to increase support system ☐ Discussed ways to increase support ☐ Referred to legal advocacy resource: _____ ☐ HM: Importance of support system* ☐ Other _____	
RF 13 DOMESTIC VIOLENCE / RF 14 CPS		
DV Services: ☐ ☐ ☐ CPS Services: ☐ ☐ ☐ Other:	☐ Referred to DV services: _____ ☐ Offered assistance in obtaining DV services* ☐ Assisted with a safety plan ☐ CPS discussed ☐ CPS report made* ☐ Assisted in engaging with CPS Services* ☐ Other: _____	
RF 15 COPING AND STRESS		
Coping strategies: ☐ Has Plan ☐ Improved Other:	☐ Discussed potential effects of stress in pregnancy ☐ Discussed strategies for coping with stress ☐ HM: Self care and coping* ☐ Other _____	
RF 16 HISTORY OF ABUSE AND OTHER ISSUES		
Other:	☐ Abuse issues explored ☐ Other: _____	

Referred to MSS: ☐ Behavioral Health Specialist ☐ Nutritionist ☐ Nurse ☐ Community Health Worker ☐ Other: _____

Next Steps: _____

Staff Signature: _____ Next Appointment: _____

Client Name: _____ Date of Birth: _____

Staff Initials: _____ Date: _____

MSS CLIENT VISIT RECORD WITH INFANT

Client Name:_____ Date of Birth: _____ Visit Date: _____

Time visit started: _____ ☐ AM ☐ PM Time visit ended: _____ ☐ AM ☐ PM

☐ HV ☐ OV Present at visit: _____

☐ See Mother's Chart for additional information: _____
Mother's Name

**Asterisked items indicate linkages and health messages (HM). Descriptions of minimum interventions can be found in the First Steps Policy and Procedures Manual under Client Services. RF = Risk Factor*

FOLLOW-UP FROM LAST VISIT (Has Plan / Contacted / Received)	INTERVENTION/ACTIONS	NOTES
NEWBORN INFANT HEALTH		
Well Child Care: ☐ ☐ ☐ Immunizations: ☐ ☐ ☐ MD: ☐ ☐ ☐ Other:	☐ Helped client develop a plan for keeping newborn free from exposure to 2nd handsmoke ☐ Well child health promotion ☐ Referred to MD for well child visit ☐ Referred to MD for medical concerns re: infant Specific Condition(s) _____ _____ ☐ Contacted _____ to advocate for client (agency) ☐ Other _____ ☐ Referred to oral health resources ☐ Facilitated oral health/medical appointment ☐ HM: Well Child Care* ☐ HM: Baby Basics* ☐ HM: Child Profile and Health Promotion ☐ HM: Tobacco/Second Hand Smoke*	☐ No change in 2nd hand exposure ☐ Change in 2nd hand exposure _____ _____ ☐ No interest in changing 2nd hand exposure ☐ Interest in decreasing 2nd hand exposure ☐ Decreased 2nd hand exposure ☐ Stopped 2nd hand exposure
NUTRITION/FEEDING/GROWTH		
Breastfeeding support: ☐ ☐ ☐ WIC ☐ ☐ ☐ Dietician ☐ ☐ ☐ Lactation Consultant ☐ ☐ ☐ MD ☐ ☐ ☐ Other:	Referred to: ☐ WIC ☐ Dietician ☐ Lactation Consultant ☐ _____ for breastfeeding support ☐ MD ☐ Other _____ ☐ Assistance with breastfeeding ☐ Gave information re: nutritional needs ☐ Nutrition/feeding information ☐ HM: Breastfeeding (in *Nine Months to Get Ready* *)	☐ Growth appears within standard guidelines

Staff Initials: _____ Date: _____

FOLLOW-UP FROM LAST VISIT	Has Plan	Contacted	Received	INTERVENTIONS/ACTIONS	NOTES
DEVELOPMENT/INFANT BEHAVIOR/BONDING					
MD	☐	☐	☐	☐ Discussed that one can't "spoil" an infant ☐ Gave age appropriate developmental information ☐ Referred for developmental evaluation	☐ Sleep patterns appear typical for age ☐ Awake periods appear typical for age ☐ Fussy periods appear typical for age ☐ Mother demonstrates bonding with infant ☐ Mother describes baby in positive terms ☐ Mother demonstrates sensitivity and appropriate responsiveness to baby
SAFETY					
Smoke Alarm Car Seat Other:	☐ ☐	☐ ☐	☐ ☐	☐ Referred to _____ (smoke alarm)* ☐ Gave information re: car seat safety* ☐ Gave car seat resources* ☐ Gave car seat ☐ Gave safety check list ☐ Gave gun safety handout ☐ Gave gun lock ☐ Gave info re: CPR training resources* ☐ Referred to: _____* ☐ HM: Back to Sleep ☐ HM: SIDS ☐ HM: Environmental Dangers* ☐ Other _____ ☐ Given car seat ☐ Contacted _____ to advocate for client. (agency) ☐ Other _____	Pets inside:_____ Pets outside: _____ Animal Pests: _____ ☐ Mother knows never to shake infant
OTHER					
Childcare:	☐	☐	☐	☐ Gave information re: finding childcare ☐ Other: _____	
ICM ENROLLMENT					
☐ Infant was enrolled in ICM services ☐ Infant was not enrolled in ICM services due to: ☐ Ineligibility ☐ Client declined services ☐ Lost contact with client ☐ Mother wanted ICM services, but was not eligible					

Referred to MSS: ☐Behavioral Health Specialist ☐Nutritionist ☐Nurse ☐Community Health Worker ☐Other: _____

Next Steps: _____

Staff Signature: _____ Next Appointment: _____

Client Name: _____ DOB: _____

MSS MOTHER'S SERVICE OUTCOME AND DISCHARGE SUMMARY

Client Name: _____

Date Discharged from MSS: _____

REASON FOR DISCHARGE FROM MSS:

☐ Client discontinued services ☐ No longer eligible
☐ Transferred to different agency ☐ Lost to follow-up
☐ Services completed ☐ Client moved
☐ Other _____

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **ANTEPARTUM: RISK FACTOR 1: PRENATAL CARE** ☐ Not evident as a risk factor ☐ Assisted in obtaining prenatal care	☐ Began prenatal care at _____ weeks gestation ☐ Obtained postpartum follow-up care on _____ ☐ Unknown
☐ **ANTEPARTUM: RISK FACTOR 2: ADJUSTMENT TO PREGNANCY** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining services related to exploration of pregnancy options	☐ Considered options, developed adequate plans and resources for parenting ☐ Considered options, working on adequate plan and resources for parenting ☐ Considered options, chose not to address ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **ANTEPARTUM: RISK FACTOR 3: MATERNAL GRIEF / LOSS** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining appropriate services	☐ Client reports that grief no longer interferes with her ability to function ☐ Client reports that grief interferes less with her ability to function ☐ Consistently working toward improving ability to function despite grief ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **BASIC NEEDS / SAFETY / ENVIRONMENT** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining appropriate services	☐ Client consistently followed up on referrals, and: ☐ Environment is safer ☐ Housing situation has improved ☐ Income situation has improved ☐ No change in situation ☐ _____ ☐ Client inconsistently followed up on referrals, and: ☐ Environment is safer ☐ Housing situation has improved ☐ Income situation has improved ☐ No change in situation ☐ _____ ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown

Client Name: _____ Date of Birth: _____

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **RISK FACTOR 4: DEVELOPMENTAL DISABILITIES / COGNITIVE IMPAIRMENT** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Informed of DDD services ☐ Assisted in obtaining DDD services ☐ Assisted in obtaining Special Education Services	☐ Client unable to obtain DDD services due to ineligibility ☐ Consistently followed up on referrals/resources, and: is receiving DDD services ☐ Client declined DDD services ☐ Client reported interest in DDD services but did not follow-up with referrals ☐ Consistently receiving Special Education services ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **NUTRITION: RISK FACTOR 5: FOOD AVAILABILITY** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Given information re: resources to obtain food	☐ Weight gain within recommended guidelines ☐ Weight gain exceeded guidelines or inadequate ☐ Weight gain less than recommended guidelines ☐ Consistently followed up on referrals/resources ☐ Received food via stamps / food bank / other, and increased food supply ☐ Inconsistently followed up on referrals/resources ☐ Client reported interest in accessing food resources but did not follow-up on referrals ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **NUTRITION: RISK FACTOR 6: SKIPPED MEALS** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address	☐ Consistently followed up on recommendations and improved nutritional behaviors ☐ Has plan to improve nutritional behaviors ☐ Reported interest in improving nutritional behaviors, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 7: MEDICAL / HEALTH / NUTRITION CONDITIOS** **SPECIFIC CONDITIONS:** _____ _____ ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Was assisted in obtaining medical care	☐ Consistently followed up on referrals/appointments, and is consistently receiving medical care ☐ Inconsistently followed up on referrals/appointments and is inconsistently receiving medical care ☐ Reported interest in receiving medical care, but no change in behaviors ☐ Client declined medical care ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown

Client Name: _____ Date of Birth: _____

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **POSTPARTUM: BREASTFEEDING / ADJUSTMENT TO PARENTING** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address	**BREASTFEEDING** ☐ Consistently followed up on referrals/recommendations and breastfeeding situation is improved ☐ Inconsistently followed up on referrals /recommendations and breastfeeding situation is not improved ☐ Reported interest in improving situation, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown **ADJUSTMENT TO PARENTING** ☐ Consistently followed up on referrals/recommendations and parenting situation is improved ☐ Inconsistently followed up on referrals/ recommendations and parenting situation is not improved ☐ Reported interest in improving situation, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 8: FAMILY PLANNING** ☐ Client referred for family planning service ☐ Pregnancy planning discussed with client ☐ Discussed HIV and STD prevention ☐ Referred for family planning services STAFF SIGNATURE: _____ DATE: _____	*(Check all that apply)* ☐ Client verbalized her hopes and dreams for her ideal family size ☐ Client reports that she thought about HIV and STDs ☐ Client decided to use contraception ☐ Client planned to obtain contraception from □ Medical Care Provider □ CSO FP Nurse □ FP Clinic □ Other ☐ Client initiated contraception after delivery (method checked below) □ Implant □ Cervical Cap □ Injectable □ Spermicides □ IUD □ Other _____ □ Female Sterilization □ Male Sterilization □ Oral Contraceptives □ Breastfeeding □ Emergency Contraception □ Withdrawal □ Condom (male) □ Abstinence □ Condom (female) □ Natural Family Planning □ Diaphragm ☐ Client has appointment to obtain contraception on: _____ ☐ No plan to use contraception ☐ Follow-up needed ☐ Plan: _____ _____ ☐ Unknown STAFF SIGNATURE: _____ DATE: _____

Client Name: _____ Date of Birth: _____

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **RISK FACTOR 9: TOBACCO USE / SECONDHAND SMOKE** ☐ Client was advised to quit tobacco use (if unwilling, was advised to cut down) _____ Staff initials and date ☐ Client was advised to avoid 2nd hand smoke and to keep her newborn from being exposed to 2nd hand smoke _____ Staff initials and date ☐ Helped client develop a quit plan ☐ Helped client develop a plan for remaining tobacco free ☐ Helped client develop a plan for keeping newborn free from exposure to 2nd hand smoke ☐ Gave "No Smoking, Baby Breathing" sign * ☐ Gave 1-800 Quit line card * ☐ Gave Fresh Start information guide * ☐ Gave "How Other Moms Have Quit" ☐ Referred to available support systems _____ _____ ☐ HM: Tobacco/Second Hand Smoke * ☐ Had client sign fax back release form	☐ No current tobacco use _____ Staff initials and date ☐ No current interest in changing tobacco use _____ Staff initials and date ☐ Has current interest in decreasing/quitting tobacco use _____ Staff initials and date ☐ Decreased tobacco use to_____ _____ Staff initials and date ☐ Stopped tobacco use _____ Staff initials and date ☐ No change in tobacco use _____ Staff initials and date ☐ No exposure to 2nd hand smoke _____ Staff initials and date ☐ No interest in decreasing 2nd hand exposure _____ Staff initials and date ☐ Interest in decreasing 2nd hand exposure_____ Staff initials and date ☐ Decreased 2nd hand exposure _____ Staff initials and date
☐ **RISK FACTOR 10: MENTAL HEALTH CONCERNS** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Was informed about and referred for mental health services ☐ Was assisted in obtaining mental health services	☐ Client unable to obtain mental health services due to lack of service availability or ineligibility ☐ Consistently followed up on referrals/appointments, is consistently receiving mental health care ☐ Inconsistently followed up on referrals/appointments, is inconsistently receiving mental health care ☐ Reported interest in receiving mental health care, but no change in behaviors ☐ Client declined mental health services ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 11: ALCOHOL / SUBSTANCE USE** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining treatment services	☐ Client unable to obtain treatment services due to lack of service availability ☐ Consistently followed up on referrals/resources, and: ☐ Client reports stopping substance /alcohol use ☐ Is consistently receiving treatment services ☐ Completed treatment program ☐ Inconsistently followed up on referrals/appointments, ☐ Client reported considering treatment program ☐ Reported interest in receiving treatment services care, but no change in behaviors ☐ Client declined treatment services ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown ☐ In treatment program ☐ Client uninterested in treatment ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown

Client Name: _____ Date of Birth: _____

RISK FACTOR / INTERVENTION INFORMATION *(Check either the Risk Factor box or the "Not Evident" box and all other boxes that apply.)*	**CLIENT OUTCOME INFORMATION** *(Check highest level[s] outcome achieved)*
☐ **RISK FACTOR 12: INADEQUATE SOCIAL SUPPORT** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Informed of importance of social support ☐ Assisted in acquiring adequate social support	☐ Consistently followed up on referrals / recommendations ☐ Improved social support ☐ Is taking steps to increase social support ☐ Inconsistently followed up on referrals recommendations ☐ Reported interest in improving situation, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 13: DOMESTIC VIOLENCE** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Linked to DV services	☐ Consistently participating with DV services ☐ Safety of situation improved ☐ Client is considering obtaining DV services ☐ Reported interest in improving situation, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 14: CPS INVOLVEMENT** ☐ Not Applicable (Not evident) ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Linked to CPS services ☐ Assisted in engaging with CPS Services	☐ Past CPS involvement (but not at onset of current MSS services) ☐ Current CPS involvement (at onset of current MSS Services) ☐ Improved situation ☐ CPS case closed ☐ Client consistently working to address ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 15: COPING AND STRESS** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Assisted in obtaining appropriate services / or increasing coping skills	☐ Consistently followed up on referrals / recommendations ☐ Coping skills have improved ☐ Actively working to improve coping skills ☐ Reported interest in improving coping skills, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ No change ☐ Unknown
☐ **RISK FACTOR 16: HISTORY OF ABUSE** ☐ Not evident as a risk factor ☐ Not addressed due to: ☐ Client had other priorities ☐ Client declined to address ☐ Abuse issues explored ☐ Assisted with obtaining appropriate services	☐ Client received appropriate services ☐ Has plan for receiving services if necessary ☐ Reported interest in improving coping skills, but no change in behaviors ☐ Client was inconsistently interested in addressing ☐ Client chose not to address ☐ No change ☐ Unknown

Client Name: _____ Date of Birth: _____

OTHER FACTORS	OUTCOME INFORMATION
BIRTH/DELIVERY OUTCOMES ☐ Referred for developmental evaluation ☐ Referred to Birth to Three Program ☐ Referred to: _____	☐ Birth weight _____ ☐ Delivered (live birth) at 37 - 40 weeks gestation ☐ Delivered (live birth) at 34 - 36 weeks gestation ☐ Delivered (live birth) at 24 - 33 weeks gestation ☐ Miscarried at ___ weeks ☐ Stillbirth ☐ Unknown
CLIENT ICM ELIGIBILITY AND ICM SERVICE STATUS ☐ Referred for ICM	☐ Eligible for ICM ☐ Continued with ICM services ☐ Eligible for ICM, client declined services ☐ Ineligible for ICM, client wanted to continue services ☐ Unknown
SCHOOL STATUS OF SCHOOL-AGED CLIENTS ☐ Out of school at onset of services ☐ In school at onset of services	☐ Returned to school ☐ Seeking return to school ☐ Has plan for return to school ☐ Reported interest in returning to school, but no change in behaviors ☐ Remained out of school, no plan to return ☐ Unknown ☐ Stayed in school ☐ Left school ☐ Unknown

Discharge Comments (optional):

_____

_____

_____

_____

Client satisfaction survey sent: ☐ Yes ☐ No

Staff Signature: _____ Date: _____

Client Name: _____ Date of Birth: _____

MSS **INFANT** SERVICE OUTCOME AND DISCHARGE SUMMARY

Client Name: _____

Date Discharged from MSS: _____

REASON FOR DISCHARGE FROM MSS:

☐ Client discontinued services ☐ No longer eligible
☐ Transferred to different agency ☐ Lost to follow-up
☐ Services completed ☐ Client moved
☐ Other:_____

AREA OF FOCUS AND INTERVENTION INFORMATION	**CLIENT OUTCOME INFORMATION**	All / Always	Some / Sometimes	None / Never	Unknown
NEWBORN INFANT HEALTH ☐ Assisted in obtaining primary care provider for infant	**Well child visits infant received:** *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Immunizations infant received: *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Recommended medical treatment infant received: *If answer is not all/always, check appropriate circle below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent appropriately cared for infant's oral health: *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent protected infant from 2nd hand smoke exposure: *If answer is not all/always, check appropriate reason below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent knows signs of illness in infant: *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent to learn, but didn't consistently wish to address ○ Parent declined ○ Topic not focused on due to other overwhelming priorities ○ Other_____	☐	☐	☐	☐

AREA OF FOCUS AND INTERVENTION INFORMATION	CLIENT OUTCOME INFORMATION
	All / Always · Some / Sometimes · None / Never · Unknown
NUTRITION/FEEDING/GROWTH ☐ Assisted in obtaining appropriate nutrition services ☐ Referred to _____ for growth concerns	**Infant's growth was:** ○ **within** ○ **below** ○ **above standard guidelines.** **If growth was not within standard guidelines, parent followed up on recommendations:** ☐ ☐ ☐ ☐ *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____ **Feeding concerns were resolved:** ☐ ☐ ☐ ☐ *If answer is not all/always, check appropriate circle below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____ **Infant is put to bed WITHOUT BOTTLE:** ☐ ☐ ☐ ☐ *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____
DEVELOPMENT/ INFANT BEHAVIOR/BONDING ☐ Assisted in obtaining developmental evaluation ☐ Referred to _____ for assistance with bonding	**Development was appropriate for age.** ○ **yes** ○ **no** **If a developmental concern was identified, parent followed up on recommendations:** ☐ ☐ ☐ ☐ *If answer is not all/always, check appropriate circle below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____ **Positive Mother / Baby bond was evident:** ☐ ☐ ☐ ☐ *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____ ☐ Infant was enrolled in Early Intervention Services

Client Name: _____ Date of Birth: _____

AREA OF FOCUS AND INTERVENTION INFORMATION	CLIENT OUTCOME INFORMATION	All / Always	Some / Sometimes	None / Never	Unknown
SAFETY ☐ Assisted in obtaining services/ safety products	**Parent reports using infant car seat:** *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent reports putting infant on back to sleep: *If answer is not all/always, check appropriate circle below:* ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
	Parent reports that pet safety is practiced: *If answer is not all/always, check appropriate circle below:* ○ Not applicable ○ Parent reported intent, but did not consistently follow up ○ Parent declined ○ Other_____	☐	☐	☐	☐
OTHER ☐ CPS report made ☐ _____	☐ CPS investigated and case not opened ☐ Infant was enrolled in CPS prevention services ☐ Infant was opened to CPS ☐ Infant was removed from parent's care ☐ Unknown				

ICM ENROLLMENT

☐ Infant was enrolled in ICM services
☐ Infant was not enrolled in ICM services due to:
☐ Ineligibility ☐ Client declined services ☐ Lost contact with client
☐ Mother wanted ICM services but was not eligible

Client satisfaction survey sent: ☐ Yes ☐ No

Discharge Comments (optional):

_____

_____

_____

_____

_____

_____

Staff Signature: _____ **Date:** _____

Client Name: _____ Date of Birth: _____